2017 External Quality Review

BLUECHOICE HEALTHPLAN OF SOUTH CAROLINA

Submitted: June 8, 2017

Prepared on behalf of the
South Carolina Department
of Health and Human Service

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. The purpose of this review was to determine the level of performance demonstrated by BlueChoice HealthPlan of South Carolina (BlueChoice) since the 2016 Annual Review. This report contains a description of the process and the results of the *2017 External Quality Review (EQR)* conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS).

Goals of the review were to:

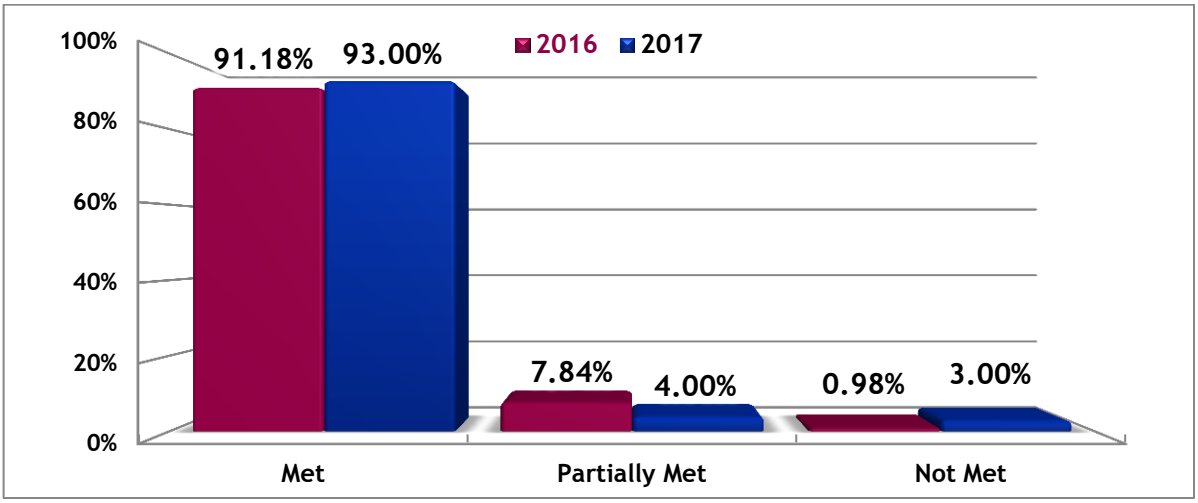
- Determine if BlueChoice was in compliance with service delivery as mandated in the MCO contract with SCDHHS.
- Evaluate the status of deficiencies identified during the 2016 Annual Review and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Assure that contracted health care services are actually being delivered and are of good quality.

The process used for the EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for Medicaid MCO EQRs. The review included a desk review of documents, a two-day onsite visit, a telephone access study, compliance review, validation of performance improvement projects (PIPSs), validation of performance improvement measures and validation of satisfaction surveys.

Overall Findings

The 2017 annual EQR review shows that BlueChoice has achieved a “Met” score for 93% of the standards reviewed. As the following chart indicates, 4% of the standards were scored as “Partially Met,” and 3% of the standards scored as “Not Met.” The chart that follows provides a comparison of BlueChoice’s current review results to the 2016 review results.

Figure 1: Annual EQR Comparative Results



An overview of the findings for each section follows. Details of the review as well as specific strengths, weaknesses, any applicable quality improvement items and recommendations can be found further in the narrative of this report.

Administration:

BlueChoice contracts with Amerigroup to perform many functions required of an MCO managing the Medicaid product in South Carolina. Policies and procedures are well organized and are generally reviewed and/or revised on an annual basis. The Compliance Plan and the Fraud, Waste, and Abuse Program Integrity Plans are up to date and include the Federal and State requirements. BlueChoice has developed comprehensive training on ethics, compliance, and fraud and abuse that is required for new employees and annually for existing employees.

CCME noted concerns about key personnel staffing. The Quality Improvement area does not have a director or manager at this time; however other trained personnel have temporarily assumed the responsibilities. BlueChoice has the services a board certified psychiatrist licensed in Florida and Kentucky at this time and was reminded that the 2016 *SCDHHS MCO Contract* requires South Carolina licensure. BlueChoice stated they have a PharmD who is also a licensed pharmacist located in Charlotte, North Carolina; however, the PharmD was not found in the pharmacy registry for either North or South Carolina. After discussion, CCME was informed that the pharmacist's license expired and was not active at the time of this review. BlueChoice is in the process of correcting this issue. This oversight points to the need for BlueChoice to ensure the process used to verify current licensure for all positions which require licensure is adequate and is being followed.

Provider Services:

BlueChoice's credentialing program is well-defined and processes are described in the Medicaid Credentialing Program Plan and several policies. We discuss the few identified issues in the "Weaknesses" section of the report. The review of credentialing and recredentialing files showed the files were organized and contained appropriate documentation.

Several issues/inconsistencies related to provider appointment availability were identified such as an incorrect standard for routine care in a policy; outdated presentations on the website that contained incorrect appointment standards; and a deficiency in the *Provider Manual* which was initially noted in the previous EQR and remains uncorrected. Also, it was unclear from reports and onsite discussion which urgent care standard ("within 24 hours" or within "48 hours") had been measured by the plan.

In addition, there were a few member benefit discrepancies identified between the *Provider Manual*, *Member Handbook*, and the BlueChoice website.

Results of the CCME-conducted telephonic *Provider Access Study* revealed a statistically significant decrease when compared to the previous year's review. The successful answer rate was 45% for the current year and 53% for the previous year.

Member Services:

BlueChoice has a responsive Customer Care Center and a comprehensive *Member Handbook* to educate members about the health plan and their benefits. The *Member Handbook* is a good resource for members to learn about access to mental health and substance abuse services. Benefits are listed in a table and described in narrative form. Several recommendations will be made to improve the content of the *Member Handbook*.

Response rates for the *Adult and Child CAHPS Survey* were 28.51% and 23.37% respectively. BlueChoice will want to continue working with vendors to increase response rates for satisfaction surveys.

Grievances files did demonstrate thorough documentation of grievance intake, investigation, and timely resolution. One grievance appeared to be a clinical quality of care issue that was not discussed with a medical director prior to resolution; however, this was the only file reviewed that did not meet policy requirements.

Quality Improvement:

BlueChoice has procedures and processes in place for measuring and improving the care and services its providers render to its members. The comparison from the previous to

the current year Healthcare Effectiveness Data and Information Set (HEDIS®) measures revealed a strong increase in Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, especially the BMI Percentile measure. There was also an increase in the Asthma Medication Ratio measures. There were decreases in rates of over 10% for a few measures including Use of Spirometry Testing in the Assessment and Diagnosis of COPD, Bronchodilator rates, and asthma medication compliance for 5-11 year olds. Both performance improvement projects scored within the "High Confidence" range.

Utilization Management:

BlueChoice contracts with Amerigroup Partnership Plan (Amerigroup) to provide administrative services for all utilization management (UM) functions. BlueChoice adopted Amerigroup's 2017 *UM Program Description* which, along with department policies, define UM functions. CCME noted various policy discrepancies and errors in the *Member Handbook* and *Provider Manual* regarding UM processes and requirements.

Annual inter-rater reliability (IRR) testing is employed to ensure consistency in medical necessity decision-making. For 2016, the average IRR of 95% was an improvement over the 2015 results. The IRR benchmark has recently been increased from 80% to 90%.

BlueChoice's Preferred Provider Program meets requirements outlined in the *SCDHHS Contract*. One provider group has achieved Gold Card status, and BlueChoice continues to evaluate providers for inclusion in the program.

Review of UM approval, denial, appeal, and case management files confirm staff members perform the respective activities appropriately. Minor, individual issues were noted in denial and appeal files; however, CCME did not identify a pattern of deficiencies.

One standard in the UM Review was scored as "Not Met" due to an uncorrected deficiency from the previous EQR.

Delegation:

BlueChoice delegates credentialing functions to four entities and complex medical case management services are delegated to one entity. Delegation agreements are in place with all delegated entities, annual oversight is conducted appropriately, and oversight results are reported to the appropriate committees. The minor issue CCME noted in the Credentialing Delegation Agreement template is the outdated reference to querying the Excluded Parties List Service as a requirement for credentialing and recredentialing. Also, the 2017 *Case Management Program Description* indicates delegation of case management functions is addressed in the program description, but no information is

found in the document. Although credentialing requirements for nurse practitioners (NPs) are not addressed in delegation agreements, oversight documentation confirms BlueChoice assesses each applicable delegate's compliance with the requirements for NPs during annual oversight activities.

State Mandated Services:

Education regarding Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including immunizations, is provided through the *Member Handbook*, *Provider Manual*, and by Provider Network Services and Quality Management staff. BlueChoice provides quarterly reports to primary care providers (PCPs) listing gaps in care for members on the provider's panel and encourages providers to reach out to the members to remind and encourage them to obtain the needed services. Provider compliance with provision of EPSDT services and immunizations is assessed via random medical record reviews performed by nurse reviewers, with interventions implemented for providers who score below the established benchmark.

Findings of this external quality review indicate BlueChoice provides all core benefits required by the *SCDHHS Contract*.

One standard in the State Mandated Services section was scored as "Not Met" due to uncorrected deficiencies from the previous external quality review.

Table 1, Scoring Overview, provides an overview of the findings of the current annual review as compared to the findings of the 2016 review.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2016	33	0	0	0	0	33
2017	31	1	1	0	0	33
Provider Services						
2016	69	5	1	0	0	75
2017	69	5	1	0	0	75
Member Services						
2016	32	4	1	0	0	37
2017	35	1	1	0	0	37

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Quality Improvement						
2016	14	1	0	0	0	15
2017	15	0	0	0	0	15
Utilization						
2016	32	6	0	0	0	38
2017	35	2	1	0	0	38
Delegation						
2016	2	0	0	0	0	2
2017	2	0	0	0	0	2
State Mandated Services						
2016	4	0	0	0	0	4
2017	3	0	1	0	0	4

METHODOLOGY

The process used by CCME for the EQR was based on CMS developed protocols for Medicaid MCO/PIHP EQRs and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On March 13, 2017, CCME sent notification to BlueChoice that the Annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow BlueChoice to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from BlueChoice on March 27, 2017 and reviewed in the offices of CCME (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was an onsite review conducted on May 11, 2017 and May 12, 2017 at the BlueChoice office located in Columbia, SC. The onsite visit focused on areas not covered in the desk review or needing clarification. See Attachment 2 for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

EQR findings are summarized in the following table and are based on the regulations set forth in title 42 of the Code of Federal Regulations (CFR), part 438, and the contract requirements between BlueChoice and SCDHHS. Strengths, weaknesses, and recommendations are identified where applicable. We identify areas of review as meeting a standard (“Met,”) acceptable but needing improvement (“Partially Met,”) failing a standard (“Not Met,”) “Not Applicable,” or “Not Evaluated,” on the tabular spreadsheet (Attachment 4).

A. Administration

The focus of the Administration review was on the health plan's policies and procedures; staffing; information system; compliance; and confidentiality practices (Health Insurance Portability and Accountability Act [HIPAA] Privacy Practices). Policies and procedures are well organized, generally reviewed annually, and revised as needed. The exception is the delayed review of several pharmacy-related policies.

Tim Vaughn has served as President and Chief Operating Officer of BlueChoice since January, 2016. Dan Gallagher is the vice president who oversees the organization's day-to-day business activities and serves as contract account manager and interagency liaison. Dr. Imtiaz Khan, DO in Family Practice, serves as medical director and is supported by Dr. Lloyd Kapp. In addition, Dr. Matthews is available approximately about 30 hours per week. The behavioral health coordinator is a licensed professional counselor. Sufficient staff is in place to meet the needs of members and provide all the services required by the contract with SCDHHS (dated July 2014).

BlueChoice was reminded that a board certified, SC-licensed psychiatrist is required for compliance to the July 2016 *SCDHHS Contract*, and one was not identified on the organizational chart. Onsite discussion revealed that Dr. Tracey Smithey, board-certified psychiatrist, is available to staff and licensed in Kentucky and Florida; however, according to BlueChoice, she is not licensed in the state of South Carolina. The process to obtain her license in South Carolina has begun. There are two vacant positions in the Quality Improvement area that include the director of clinical quality management and the quality manager.

The BlueChoice Compliance Plan and Fraud and Abuse Program Integrity Plan are consistent with Federal and State requirements. The *Provider Manual* and *Member Handbook* contain the South Carolina Medicaid Fraud Hotline and email address, BlueChoice hotline phone numbers, fax numbers, and sufficient information to report suspicion of fraud, waste, or abuse anonymously. Fraud and abuse information available on the BlueChoice website was difficult to locate and very limited in scope. There was no easy access or link to this information on the website. One document titled "What To Know About Fraud and Abuse" is dated 2008, and does not include the BlueChoice Hotline number.

BlueChoice meets the organization's internal requirements and surpasses the MCO contract requirements by completing 98% of claims in 30 days and 99% within 90 days. Anthem conducted a disaster recovery exercise in June 2016.

BlueChoice received "Met" scores for 93.9% of the standards in the Administration review. Scores of "Partially Met" (3%) are due to inconsistent documentation of Compliance Committee membership, the "Not Met" score (3%) was due to the pharmacy director's expired pharmacist license.

Figure 2: Administration Findings

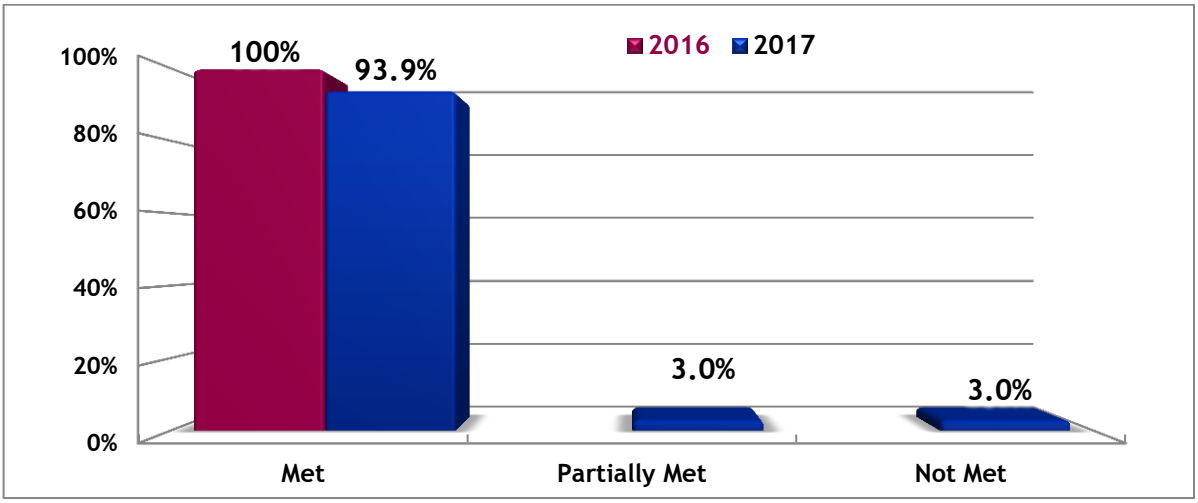


Table 2: Administration Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Organizational Chart / Staffing	Pharmacy Director	Met	Not Met
Compliance / Program Integrity	The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- The Compliance Plan includes training requirements for staff and subcontractors. BlueChoice has multiple processes in place to identify, prevent, and take action on inappropriate use of Medicaid services or funds.

- BlueChoice has developed a quarterly newsletter to ensure BlueChoice employees are kept up to date and continually reminded about privacy and protected health information (PHI). In addition, they have another staff newsletter addressing compliance issues.
- BlueChoice meets internal and SCDHHS goals for claims payment with 98% of claims processed within 30 days and 99% processed within 90 days.

Weaknesses

- The process for annual policy review and revision, and the committee with the responsibility for policy review, were absent.
- Onsite discussion confirmed that Dan Gallagher serves as contract account manager. The organizational chart does not clearly identify Dan Gallagher in this position.
- Suzanne Trautman is a PharmD and a pharmacist; however, she is not found on the SC or NC Board of Pharmacy registries as a licensed pharmacist and according to BlueChoice, Ms. Trautman has an expired license. According to the *SCDHHS Contract, Exhibit 1*, the pharmacy director must be appropriately licensed as a pharmacist in the state in which they operate.
- BlueChoice has a board certified psychiatrist available for oversight and development of the Behavioral Health Program. Dr. Smithey is licensed in the states of Florida and Kentucky and is in the process of obtaining South Carolina licensure. See the *SCDHHS Contract, Section 2, Exhibit 1* (July 2016) for details on the requirements for this position.
- The positions of quality manager and director of clinical quality management are vacant.
- The Fraud and Abuse Program Integrity Plan did not include a date when it was last reviewed or updated.
- The membership list in the Compliance Committee Charter is not consistent with the committee membership list.
- Onsite discussion concluded that new employees are trained in privacy and confidentiality prior to access to PHI; however, this is not found in any document, policy, or the HIPAA Privacy Operational Requirements document.

Quality Improvement Plans

- Ensure the pharmacy director meets the contract requirements. Describe the process used to verify licensure for the pharmacist and other staff requiring licensure and ensure the process is being followed.
- Update membership lists for the Compliance Committee to be in agreement with each other.

Recommendations

- Document in a policy/procedure or other format the staff or committee responsible for policy review and revision and the process for conducting the reviews annually.
- Update the organization chart to indicate who is in the position of contract account manager.
- Ensure BlueChoice is compliant with contract requirements for a board certified, SC-licensed psychiatrist.
- BlueChoice is encouraged to fill vacant Quality Improvement positions with qualified staff as soon as possible.
- Ensure the date of the last update or review of the Fraud and Abuse Program Integrity Plan appears on the document.
- Update Policy MCD-09, Privacy and Confidentiality, to indicate HIPAA training is conducted prior to any access to PHI. The American Health Information Management Association (AHIMA) recommends this best practice guideline.

B. Provider Services

CCME conducted a review of all policies, procedures, the provider agreement, provider training and educational materials, provider network information, credentialing and recredentialing files, and practice guidelines for Provider Services.

The medical director, Dr. Lloyd Kapp, chairs the Credentialing Committee and has primary responsibility and oversight for all credentialing activities, including the approval of policies and procedures. Additional committee members include the vice president of medical affairs and nine network providers with specialties including internal medicine; pediatrics; chiropractic; surgery; pulmonology; OB/GYN; and dental. Only network providers on the committee have voting privileges, and a quorum is met with three network providers in attendance. The Credentialing Committee reviews "clean files" on a weekly basis, and focused reviews of "unclean files" occur bi-monthly. A review of committee minutes showed detailed discussion and confirmed the quorum was met at each meeting.

For behavioral health practitioners, the Companion Benefit Alternative (CBA) Credentialing Committee has the responsibility for credentialing and recredentialing decisions.

BlueChoice's credentialing program is well-defined and processes are described in the *Medicaid Credentialing Program Plan* and several policies. CCME identified a few issues which are discussed in the "Weaknesses" section that follows. The review of BlueChoice's

credentialing and recredentialing files showed the files were organized and contained appropriate documentation.

CCME identified several issues/inconsistencies related to provider appointment availability. These included an incorrect standard for routine care in a policy; outdated presentations on the website that contained incorrect appointment standards; and an issue identified during the previous EQR was not corrected in the *Provider Manual*. In addition, it was unclear from reports and onsite discussion which urgent care standard ("within 24 hours" or within "48 hours") was measured by the plan.

CCME also noted a few member benefit discrepancies identified between the *Provider Manual*, *Member Handbook*, and the BlueChoice website.

Provider Access and Availability Study

As part of the annual EQR process for BlueChoice HealthPlan, CCME conducted a *Telephonic Provider Access Study* that focused on primary care providers (PCPs). A list of current providers was given to CCME by BlueChoice, from which we identified a population of 2,162 unique PCPs. CCME randomly selected a sample of 311 providers from this population for the *Telephonic Provider Access Study*. We made attempts to contact these providers to ask a series of questions regarding the access that members have with the contracted providers.

In reference to the results of the *Telephonic Provider Access Study*, conducted by CCME, calls were successfully answered 45% of the time (141/311) by personnel at the correct practice, which estimates between 43 and 48% for the entire population using a 95% confidence interval. When compared to last year's results of 53%, this year's study had a statistically significant decrease in successfully answered calls (Z=2.03, p=.04).

For those not answered successfully (n=170 calls), 76 (48%) were unsuccessful because the provider was not at that office or phone number listed. Of the 141 successful calls, 113 (80%) of the providers indicated that they accept BlueChoice. Of the 113 that accept BlueChoice, 90 (80%) responded that they are accepting new Medicaid patients.

When asked about any screening process for new patients, 46 (49%) of the 94 providers that responded to the item indicated that an application or prescreen was necessary. Of those 46, 7 (15%) indicated that an application must be filled out, whereas 6 (13%) require a review of medical records before accepting a new patient and 21 (46%) require both. When the office was asked about the next available routine appointment, 71 responses (73%) of the 97 responses met contact requirements.

Figure 3, Provider Services Findings, shows that 92% of the standards in Provider Services received a "Met" score. *Table 3, Provider Services Comparative Data,* highlights standards that showed a change in score from 2016 to 2017.

Figure 3: Provider Services Findings

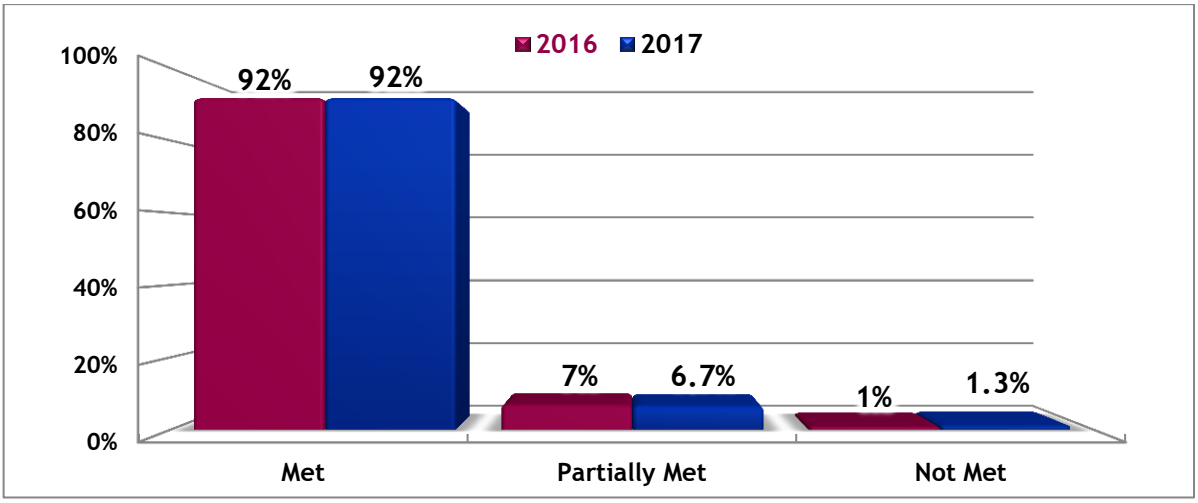


Table 3: Provider Services Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Credentialing and Recredentialing	The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements	Met	Partially Met
	Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO	Partially Met	Met
	Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Met	Partially Met
Adequacy of the Provider Network	The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually	Partially Met	Met

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Provider Education	Initial provider education includes: Billing and reimbursement practices	Partially Met	Met
	Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- BlueChoice is auditing all documents and content on their website to ensure the information is up to date and accurate.
- The *Provider Manual* is a good resource document as is other educational and reference information on the provider portal of the BlueChoice website.
- Credentialing and recredentialing files contained appropriate documentation.

Weaknesses

- A few issues were noted in the *Medicaid Credentialing Program Plan*:
    - Section VI. A. does not address that queries are performed for the Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE) and the SC Excluded Provider List.
    - Section IV. B. does not mention collection of the Disclosure of Ownership form or queries performed for organizational providers.
- Policy MCD-06, Health Care Delivery Organizations – Credentialing/Recredentialing, does not address what queries are performed or the collection of the Disclosure of Ownership form.
- Policy SC_PNXX_309, Excluded and Debarred Providers – BlueChoice, discusses monitoring at initial credentialing and monthly for excluded and debarred providers, but the list of queries is different than what is listed in Policy MCD-07. Onsite discussion revealed that Policy SC_PNXX_309 is an Amerigroup policy that may duplicate processes already addressed in Policy MCD-07.
- Physician office accessibility standards are defined in Policy MCD-11, Medicaid Access/ Availability Standards. The policy states a four- to six-week appointment standard for routine care appointments; however, the *Provider Manual* and the 2016 provider education presentation define the timeframe as four weeks. In addition, the 2016 QAPI

Annual Evaluation shows the four-week timeframe for routine care appointments as being measured.

- The presentations (Overview for Physicians-Feb. 2015 & Overview for Facilities-Feb. 2015) found on the Education, Training and Resources section of the website state routine care is "within 4 – 6 weeks". The presentations also mention a standard of "sick care appointment within three days of presentation" which is not mentioned in Policy MCD-11 or the *Provider Manual*.
- In the previous EQR, BlueChoice indicated they would add the following appointment standard to the *Provider Manual*, "Health Maintenance/Preventive Care: within 8 weeks," since this was a standard being measured by the plan. However, the information does not appear in the *Provider Manual* received in the desk materials.
- The *BlueChoice HealthPlan Medicaid Practitioner Access Analysis* report (2015) and the *2016 QAPI Program Evaluation* (page 39) states that for 2015, a total of 13 practitioner onsite visit contacts were made to measure practitioner-level appointment standards. The appointment standard measured for urgent care was an office visit "within 24 hours;" however, Policy MCD-11 and the *Provider Manual* define the urgent care standard as "within 48 hours".
- The *Telephonic Provider Access Study* conducted by CCME revealed a statistically significant decrease when compared to last year's results (from 53% for the previous review to 45% for this review).
- There are inconsistencies in copayment and benefit information listed in the *Provider Manual* (page 15), *Member Handbook* (page 10), and the copay information page of the website:
    - EPSDT "well-child visits/services" is listed in the *Provider Manual* and not in the *Member Handbook* or website.
    - "Rehabilitative behavioral health services" is listed in the *Member Handbook* and not the *Provider Manual* or the website.
    - "No prescription copay" for family planning medicine, smoking cessation drugs, behavioral health drugs, and certain diabetic medications is listed in the *Provider Manual* and *Member Handbook* but not on the website.
    - "Outpatient Services" (*Provider Manual*, page 22) lists a $3.30 copay when the *Member Handbook* and website state a $3.40 copay.
    - "Psychiatric Assessment Services" (*Provider Manual*, page 25) states a one assessment limit per member every 12 months but the *Member Handbook* (page 20) states every 6 months. Onsite discussion confirmed it should be every 6 months.

- The *Provider Manual* does not include instructions on how to reassign a member to another PCP.
- The *2017 Quality Assessment Performance Improvement Program Description* has an outdated statement on page 27 as follows, "After internal review, changes recommended for 2014 will be presented to the Clinical Quality Improvement Committee (CQIC) for approval and adoption."

Quality Improvement Plans

- Update the Medicaid Credentialing Program Plan to include all queries performed for physicians and organizational providers, and the collection of ownership disclosure forms for organizational providers.
- Update Policy MCD-06, Health Care Delivery Organizations – Credentialing / Recredentialing, to include the queries that are performed and the collection of Disclosure of Ownership forms.
- Address inconsistencies in Policies MCD-07 and SC_PNXX_309 regarding the queries performed and the process of monthly provider monitoring. If Policy SC_PNSS_309 is retired, ensure that MCD-07 is updated to address all queries and the monthly provider monitoring process being performed.
- Update Policy MCD-11, Medicaid Access/Availability Standards, to reflect a four-week timeframe for routine care appointments.
- Update the provider training presentations (Overview for Physicians-Feb. 2015 & Overview for Facilities-Feb. 2015) on the website to accurately reflect the appointment standards.
- Update the *Provider Manual* to reflect the "Health Maintenance/Preventive Care" standard that was identified in the previous EQR.
- Ensure the measurement for the urgent care appointment standard reflects the "within 48 hours" standard being communicated to providers.
- Regarding member's access to their providers, identify and address barriers in the update process so that having up-to-date contact information for members is not an issue.
- Correct the member benefit discrepancies identified between the *Provider Manual*, *Member Handbook*, and the BlueChoice website.

Recommendations

- Update the *Provider Manual* to include instructions on how to reassign a member to another PCP.

- Correct the following outdated statement on page 27 of the *2017 Quality Assessment Performance Improvement Program Description*, "After internal review, changes recommended for 2014 will be presented to the CQIC for approval and adoption."

C. Member Services

The review of Member Services included policies and procedures, member rights, member materials and the handling of grievances, disenrollment, and practitioner changes. BlueChoice has a Customer Care Center (CCC) available by a toll-free number from 8:00 a.m. to 6:00 p.m. Monday through Friday; a 24-hour Nurseline; TTY capabilities; and translation services as required. BlueChoice continues to meet or surpass goals set by the State and internal goals for call metrics in their CCC in Savannah, Georgia. Bilingual staff are available in the CCC when needed.

The *Member Handbook* includes very good information on Advance Directives, how to obtain care, and benefits, both in a table and in narrative form. Member rights and responsibilities are well documented across plan materials. The *Member Handbook* is well done; however, CCME includes several recommendations to improve the content. Behavioral health services are well defined in the *Member Handbook* and access to these services is available by calling the CCC during the day and Nurseline 24 hours a day.

Grievance file review indicates that BlueChoice acknowledges, thoroughly investigates, and resolves grievances within a 30-day timeframe. One potential quality of care grievance was not reviewed by a medical director before resolution.

BlueChoice contracts with DSS Research, a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey vendor, to conduct both the child and adult surveys. The Service Quality Improvement Committee (SQIC) and CQIC analyzed the reports, presented the results, and decided on interventions/initiatives to address problematic areas of member satisfaction. Response rates for the Adult and Child CAHPS survey were 28.51% and 23.37% respectively. BlueChoice will want to continue working with vendors to increase response rates for satisfaction surveys. The results were reported to the providers in a stand-alone document called "CAHPS Results Provider Notification" via Healthy Connections newsletter. Members did not receive results from the child survey.

BlueChoice received "Met" scores for 94.6% of the standards for the Member Services Review. Scores of "Partially Met" and "Not Met" are due to a discrepancy between a policy and the *Member Handbook* regarding grievance acknowledgement, a minor correction needed in the 'Grievance and Appeal Rights" document, and one uncorrected deficiency from the previous EQR.

Figure 4: Member Services Findings

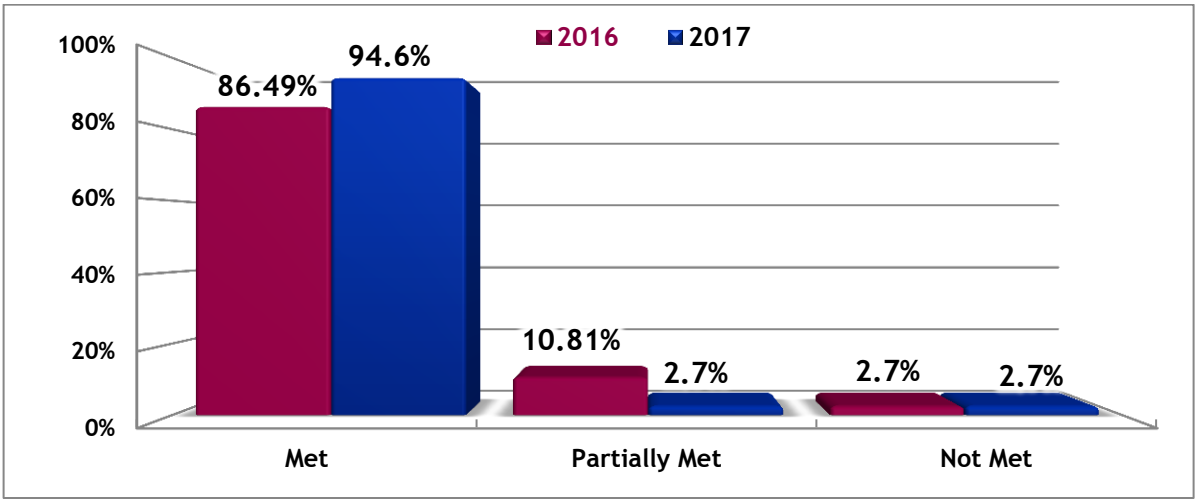


Table 4: Member Services Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Member MCO Program Education	A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;	Partially Met	Not Met
	Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	Partially Met	Met
Grievances	The MCO applies the grievance policy and procedure as formulated.	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- Grievance files reviewed indicated appropriate documentation of acknowledgement and investigation, and resolution of grievances was conducted within timeliness guidelines.

- The *Member Handbook* provides very good information on Advance Directives, behavioral health, and all member benefits and services.

Weaknesses

- It is not documented in policy that *Member Handbooks* and other educational materials are supplied within 14 days of enrollment. Reference the *SCDHHS Contract dated 2014, Sections 3.12.2 and 3.12.6, or 2016 SCDHHS Contract, Section 3.15.3.*
- The *Member Handbook* states member rights include receiving information about the health plan service area; however the service area is not found in the *Member Handbook*.
- Second opinions are only addressed in the glossary section of the *Member Handbook*. The information provided meets the requirement of the contract; however, members are not likely to go to the glossary to find it.
- The following pharmacy policies have not been reviewed in over 18 months:
  - PMXX-005
  - PMX-010
  - PMXX-015
  - PMXX-020

  Onsite discussion confirmed policies undergo annual review.

- Policy SC_PNXX_303, Provider Termination and Member Notification, page 2, incorrectly states "If BlueChoice HealthPlan Medicaid learned about the termination after the fact, the letter is sent as soon as possible but no later than 30 calendar days after learning of the termination."
- The electronic version of the *Member Handbook* received with the desk materials did not contain a PCP Selection Form as indicated on page 25. BlueChoice demonstrated that the print edition does contain the form and the form can be obtained on the website.
- The BlueChoice website is in the process of being updated and the language has changed for easier understanding. (Find a Doctor replaced Provider Directory.) This change was not made in the *Member Handbook*.
- The *Member Handbook* includes links to the America Medical Association and American Board of Medical Specialists to obtain more information about providers. These links were not functioning at the time of this review.
- No fax number to the CCC or Member Services area is provided. This item was noted in the previous EQR and a Quality Improvement Plan was submitted in which a fax number was included in the *Member Handbook*. It appears this plan was not implemented. See the *SCDHHS Contract (2014), Section 3.9.1.23,* and *the SCDHHS Contract (2016), Section 3.14.1.10.*

- The BlueChoice Medicaid website does not provide a direct link to information regarding fraud and abuse. In addition, the search feature is not helpful in finding this information. One document found on the website titled "What to Know About Fraud and Abuse" is dated October, 2008. It does not include the BlueChoice Hotline number as required by the BlueChoice Compliance Plan.
- *Federal Regulation § 438.3 (d) (4),* effective July 2017, states "The MCO, PIHP, PAHP, PCCM or PCCM entity will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability." See also the *SCDHHS Contract (2016), Sections 3.4.6 and 19.11.* Several versions of this list occur in plan documents including the *Member Handbook* and the *Provider Manual*.
- BlueChoice provided a copy of their Marketing Plan during the onsite visit. Page nine of this plan indicates marketing materials will be produced at a seventh grade educational level or lower. Please refer *to SCDHHS Contract (2016), Section 3.16.1.2,* or the *2014 SCDHHS Contract, Section 3.13.1.1.2,* and *Managed Care Organizations Policy & Procedure Guide*.
- The *Member Handbook*, page 67, indicates that BlueChoice can deny a request to leave the plan (disenroll) for cause or good reason. However, only Healthy Connections Choices can deny requests to disenroll from a health plan.
- Community Events are listed on the BlueChoice website. Page 2 of the *Member Handbook* states one of the extra benefits are community events. Onsite discussion confirms members can learn about the events from flyers left at provider offices, in the community, or by accessing the calendar on the website. There is no guidance in the *Member Handbook* about how members learn about these events.
- Response rates for the Adult and Child CAHPS survey were 28.51% and 23.37% respectively.
- Page 60 of the *Member Handbook* states a grievance is a request to look into an issue with quality of care or service. This statement appears to limit the scope of grievances a member could file.
- A discrepancy was found regarding acknowledging grievances between pages 4 of Policy SC_GAXX_015, Grievance Process: Members, and the *Member Handbook*, page 61.
- One grievance file reviewed appeared to be a possible clinical quality of care issue; however, the file did not indicate that a medical director had been consulted about this or involved in the resolution.

- One minor correction in the "Grievance and Appeal Rights" document is needed to update the language on page one from "must" to "may".

Quality Improvement Plans

- Update the *Member Handbook* to include the service area covered by BlueChoice.
- Update Policy SC_PNXX_303, Provider Termination and Member Notification, by including the correct timeframe for notice on page two of the policy.
- Update the *Member Handbook* to include a fax number for members to contact the CCC or Member Services.
- Update the BlueChoice website to include easier access to fraud, waste, and abuse information and add the toll-free BlueChoice hotline phone number for members to report fraud and abuse issues.
- Correct the discrepancy between the policy and the *Member Handbook* regarding how grievances are acknowledged.
- Correct the remaining error in the "Grievance and Appeal Rights" document.

Recommendations

- Include in Policy MCD-09 or a different policy or procedure that members are sent *Member Handbook*s and member educational materials no later than 14 calendar days from the receipt of enrollment data.
- Include information about second opinions with benefit information in the body of the *Member Handbook*.
- Ensure policies are reviewed according to the internal process.
- Ensure the PCP Selection Form is available in all versions of the *Member Handbook*.
- Update the language used in the *Member Handbook,* page 26, to reflect changes to the language used on the website. Ensure links provided for members are functional.
- Ensure consistent information is provided to members, staff, and providers regarding anti-discrimination law.
- Update the Marketing Plan to indicate materials will be produced below a 7th grade reading level.
- Update the *Member Handbook* to remove the reference to BlueChoice denying a member request to disenroll.
- Update the *Member Handbook* to include that members may access the calendar of events on the website or call the CCC to learn about community events.

- Implement strategies to increase CAHPS survey response rates such as website or email announcements, bulletin postings, call center script additions that remind members of the survey, placing stamps on survey envelopes, and incentives for members.
- Update the definition of a grievance found on page 60 of the *Member Handbook*.
- Develop a training plan for CCC and Grievance and Appeals staff to ensure they are following policy regarding the types of grievances that should be brought to the attention of a medical director for consultation or review prior to resolution.

D. Quality Improvement

BlueChoice presented the 2017 *Quality Assessment Performance Improvement Program Description* for review. The program description is reviewed, updated as needed, and presented to various quality improvement committees and to the Board of Directors for approval. There were two discrepancies or incorrect information noted in the program description regarding Community Resource Centers and the frequency for reviewing and updating materials. Annually, BlueChoice develops a work plan that outlines the planned activities. Revisions and updates are made as needed and reported to the Clinical Quality Improvement Committee (CQIC) for approval.

BlueChoice's CQIC and Service Quality Improvement Committee (SQIC) are charged with authority and accountability for all PIPs and processes. The CQIC is chaired by Dr. Lloyd Kapp, and the SQIC is chaired by the senior manager, quality improvement and accreditation. There are 11 network providers represented on the CQIC. All are voting members of that committee. Three external physicians are needed to meet the quorum requirements for the CQIC. A quorum has not been established for the SQIC. Both committees meet quarterly. Committee minutes are well documented.

BlueChoice uses the *Quality Assessment and Performance Improvement Program Evaluation* to evaluate the progress and results of planned activities toward established goals. The 2016 *Quality Assessment Performance Improvement Program Evaluation* was provided for review.

Performance Measure Validation

CCME conducted a Validation Review of the HEDIS performance measures following CMS developed protocols. This process assesses the application of these measures by the health plan to confirm reported information is valid.

BlueChoice uses Quality Spectrum Insight (QSI) by Inovalon, a certified software organization, to calculate HEDIS rates and verify the measures are fully compliant and consistent with CMS protocol requirements.

The comparison from the previous to the current year revealed a strong increase in Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, especially the BMI Percentile measure. There was also an increase in the Asthma Medication Ratio measures. There were decreases in rates of over 10% for a few measures including Use of Spirometry Testing in the Assessment and Diagnosis of COPD, Bronchodilator rates, and asthma medication compliance for 5-11 year olds. Effort should be made to increase the measures that had a drop of more than 10% from last year to this year. All relevant HEDIS performance measures are detailed in *Table 5: HEDIS Performance Measure Data*.

Table 5: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	MEASURE YEAR 2014	MEASURE YEAR 2015	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	82.20%	84.03%	1.83%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	49.65%	70.37%	20.72%
Counseling for Nutrition	48.96%	57.18%	8.22%
Counseling for Physical Activity	40.60%	47.69%	7.09%
Childhood Immunization Status (cis)			
DTaP	78.94%	70.37%	-8.57%
IPV	90.51%	85.65%	-4.86%
MMR	89.81%	82.87%	-6.94%
HiB	86.11%	78.24%	-7.87%
Hepatitis B	91.90%	83.80%	-8.10%
VZV	90.28%	82.41%	-7.87%
Pneumococcal Conjugate	81.71%	74.54%	-7.17%
Hepatitis A	86.34%	79.63%	-6.71%
Rotavirus	73.61%	71.76%	-1.85%
Influenza	43.75%	34.72%	-9.03%

MEASURE/DATA ELEMENT	MEASURE YEAR 2014	MEASURE YEAR 2015	PERCENTAGE POINT DIFFERENCE
Combination #2	73.61%	65.28%	-8.33%
Combination #3	71.53%	63.89%	-7.64%
Combination #4	69.21%	61.34%	-7.87%
Combination #5	58.33%	55.56%	-2.77%
Combination #6	37.04%	28.94%	-8.10%
Combination #7	56.94%	53.94%	-3.00%
Combination #8	36.34%	28.70%	-7.64%
Combination #9	31.02%	25.69%	-5.33%
Combination #10	31.02%	25.46%	-5.56%
Immunizations for Adolescents (ima)			
Meningococcal	60.88%	62.88%	2.00%
Tdap/Td	83.10%	84.92%	1.82%
Combination #1	60.42%	62.65%	2.23%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	15.74%	15.81%	0.07%
Lead Screening in Children (lsc)	50.23%	57.41%	7.18%
Breast Cancer Screening (bcs)	49.74%	49.34%	-0.40%
Cervical Cancer Screening (ccs)	51.64%	50.12%	-1.52%
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	4.17%	2.49%	-1.68%
Chlamydia Screening in Women (chl)			
16-20 Years	46.94%	43.47%	-3.47%
21-24 Years	54.76%	54.76%	0.00%
Total	49.38%	47.48%	-1.90%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	74.53%	77.39%	2.86%

MEASURE/DATA ELEMENT	MEASURE YEAR 2014	MEASURE YEAR 2015	PERCENTAGE POINT DIFFERENCE
Appropriate Treatment for Children With URI (uri)	82.44%	84.64%	2.20%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	24.29%	21.96%	-2.33%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	37.90%	27.33%	-10.57%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	56.73%	48.71%	-8.02%
Bronchodilator	81.63%	69.79%	-11.84%
Use of Appropriate Medications for People With Asthma (asm)			
5-11 Years	90.10%	NR	NA
12-18 Years	86.51%	NR	NA
19-50 Years	69.16%	NR	NA
51-64 Years	NR	NR	NA
Total	84.87%	NR	NA
Medication Management for People With Asthma (mma)			
5-11 Years - Medication Compliance 50%	60.85%	47.14%	-13.71%
5-11 Years - Medication Compliance 75%	34.93%	23.57%	-11.36%
12-18 Years - Medication Compliance 50%	55.05%	46.72%	-8.33%
12-18 Years - Medication Compliance 75%	26.15%	21.83%	-4.32%
19-50 Years - Medication Compliance 50%	62.16%	60.87%	-1.29%
19-50 Years - Medication Compliance 75%	37.84%	31.88%	-5.96%
51-64 Years - Medication Compliance 50%	NA	72.22%	NA
51-64 Years - Medication Compliance 75%	NA	44.44%	NA
Total - Medication Compliance 50%	59.21%	48.91%	-10.30%
Total - Medication Compliance 75%	32.78%	24.32%	-8.46%

MEASURE/DATA ELEMENT	MEASURE YEAR 2014	MEASURE YEAR 2015	PERCENTAGE POINT DIFFERENCE
Asthma Medication Ratio (amr)			
5-11 Years	74.29%	79.42%	5.13%
12-18 Years	53.20%	65.40%	12.20%
19-50 Years	38.46%	47.22%	8.76%
51-64 Years	NA	37.14%	NA
Total	61.38%	69.28%	7.90%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	53.26%	43.49%	-9.77%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	NA	80.95%	NA
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	86.71%	84.49%	-2.22%
HbA1c Poor Control (>9.0%)	51.05%	47.92%	-3.13%
HbA1c Control (<8.0%)	43.36%	45.37%	2.01%
HbA1c Control (<7.0%)	NR	NR	NA
Eye Exam (Retinal) Performed	33.33%	30.32%	-3.01%
Medical Attention for Nephropathy	80.89%	91.90%	11.01%
Blood Pressure Control (<140/90 mm Hg)	56.64%	51.39%	-5.25%
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	56.45%	62.50%	6.05%
Use of Imaging Studies for Low Back Pain (lbp)	71.60%	70.88%	-0.72%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			

MEASURE/DATA ELEMENT	MEASURE YEAR 2014	MEASURE YEAR 2015	PERCENTAGE POINT DIFFERENCE
Effective Acute Phase Treatment	41.07%	41.45%	0.38%
Effective Continuation Phase Treatment	30.24%	26.53%	-3.71%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	35.71%	32.89%	-2.82%
Continuation and Maintenance (C&M) Phase	45.71%	44.24%	-1.47%
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-Day Follow-Up	NR	NR	NA
7-Day Follow-Up	NR	NR	NA
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	81.63%	79.18%	-2.45%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	68.00%	61.82%	-6.18%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NA	100.00%	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	58.65%	55.70%	-2.95%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NA	NA	NA
6-11 Years	NR	2.86%	NA
12-17 Years	NR	3.23%	NA
Total	NR	3.13%	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	NA	20.00%	NA
6-11 Years	22.41%	23.53%	1.12%
12-17 Years	23.62%	22.48%	-1.14%
Total	22.99%	22.70%	-0.29%

MEASURE/DATA ELEMENT	MEASURE YEAR 2014	MEASURE YEAR 2015	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	85.45%	84.24%	-1.21%
Digoxin	65.71%	59.26%	-6.45%
Diuretics	86.71%	83.78%	-2.93%
Total	85.75%	83.83%	-1.92%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	78.20%	77.46%	-0.74%
45-64 Years	85.93%	86.52%	0.59%
65+ Years	NA	100.00%	NA
Total	80.59%	80.31%	-0.28%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	94.01%	96.37%	2.36%
25 Months - 6 Years	85.17%	85.07%	-0.10%
7-11 Years	87.62%	85.76%	-1.86%
12-19 Years	84.97%	83.69%	-1.28%
Annual Dental Visit (adv)			
2-3 Years	NB	NB	NA
4-6 Years	NB	NB	NA
7-10 Years	NB	NB	NA
11-14 Years	NB	NB	NA
15-18 Years	NB	NB	NA
19-21 Years	NB	NB	NA

MEASURE/DATA ELEMENT	MEASURE YEAR 2014	MEASURE YEAR 2015	PERCENTAGE POINT DIFFERENCE
Total	NB	NB	NA
Initiation and Engagement of AOD Dependence Treatment (iet)			
Initiation of AOD Treatment: 13-17 Years	39.17%	38.68%	-0.49%
Engagement of AOD Treatment: 13-17 Years	25.00%	26.42%	1.42%
Initiation of AOD Treatment: 18+ Years	39.52%	32.27%	-7.25%
Engagement of AOD Treatment: 18+ Years	7.31%	7.62%	0.31%
Initiation of AOD Treatment: Total	39.49%	32.69%	-6.80%
Engagement of AOD Treatment: Total	8.90%	8.85%	-0.05%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	93.57%	85.98%	-7.59%
Postpartum Care	71.47%	70.56%	-0.91%
Call Answer Timeliness (cat)	82.89%	88.85%	5.96%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	NA	100.00%	NA
6-11 Years	NA	11.11%	NA
12-17 Years	14.00%	17.31%	3.31%
Total	15.58%	19.18%	3.60%
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
<21 Percent	7.50%	7.68%	0.18%
21-40 Percent	3.70%	5.09%	1.39%
41-60 Percent	6.89%	7.49%	0.60%
61-80 Percent	15.83%	15.69%	-0.14%
81+ Percent	66.08%	64.06%	-2.02%

MEASURE/DATA ELEMENT	MEASURE YEAR 2014	MEASURE YEAR 2015	PERCENTAGE POINT DIFFERENCE
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	1.65%	0.98%	-0.67%
1 Visit	3.07%	2.45%	-0.62%
2 Visits	1.42%	2.21%	0.79%
3 Visits	5.66%	5.64%	-0.02%
4 Visits	7.08%	7.11%	0.03%
5 Visits	18.87%	17.16%	-1.71%
6+ Visits	62.26%	64.46%	2.20%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	66.44%	64.87%	-1.57%
Adolescent Well-Care Visits (awc)	43.52%	36.34%	-7.18%

NB: Not a benefit; NR: Not reported; NA: Data not available

Performance Improvement Project Validation

CCME validated performance improvement projects (PIPs) in accordance with CMS protocol titled, *"EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012."* The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

Two projects were validated using the CMS Protocol for Validation of Performance Improvement Projects. They included Access and Availability of Care and Childhood Immunizations, Combo 3 and Lead Screening. Table 6, *Performance Improvement Project Validation Scores,* provides an overview of each project's validation score.

Table 6: Performance Improvement Project Validation Scores

PROJECT	2016 VALIDATION SCORE	2017 VALIDATION SCORE
Access and Availability of Care	46/56=82% Confidence in Reported Results	113/118=96% High Confidence in Reported Results
Childhood Immunizations Combo 3 and Lead Screenings	90/93=96% High Confidence in Reported Results	125/131=95% High Confidence in Reported Results

Both projects were chosen based on sound data analysis and the rationale was provided. There are two main issues: the terminology used for long-term goal and benchmarks is unclear, because the long-term goal is typically the benchmark. The other concern is improvement in the rates. For the Access and Availability of Care project, there is only baseline data so improvement cannot be evaluated. For the Childhood Immunizations Combo 3 and Lead Screening project, it was noted that there were increases for the Lead Screening, but the Combo 3 rate decreased from the previous measurement. The following table lists the specific errors by project along with recommendations.

Table 7: Performance Improvement Project Errors and Recommendations

Project	Section	Reasoning	Recommendation
Access and Availability of Care	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly	The baseline goal should be a short-term goal, whereas the benchmark is the long-term goal.	Adjust documentation of benchmarks so that the benchmark is the highest rate; and the goal rate is higher than the current known rate (goal is the baseline goal).
Childhood Immunizations Combo 3 and Lead Screenings	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly	The baseline goal should be a short-term goal, whereas the benchmark is the long-term goal.	Adjust documentation of benchmarks so that the benchmark is the highest rate; and the goal rate is higher than the current known rate (goal is the baseline goal).

Project	Section	Reasoning	Recommendation
	Is there any statistical evidence that any observed performance improvement is true improvement?	Combo 3 does not have statistically significant improvement from baseline, although Lead Screening rates have increased significantly from baseline when compare to Remeasurement 2.	Continue to adapt interventions focused on increasing Combo 3 vaccination rates.

Details of the validation of the performance measures and PIPs may be found in the *CCME EQR Validation Worksheets, Attachment 3*.

Figure 5, Quality Improvement Findings, indicates that all of the standards received a "Met" score.

Figure 5: Quality Improvement Findings

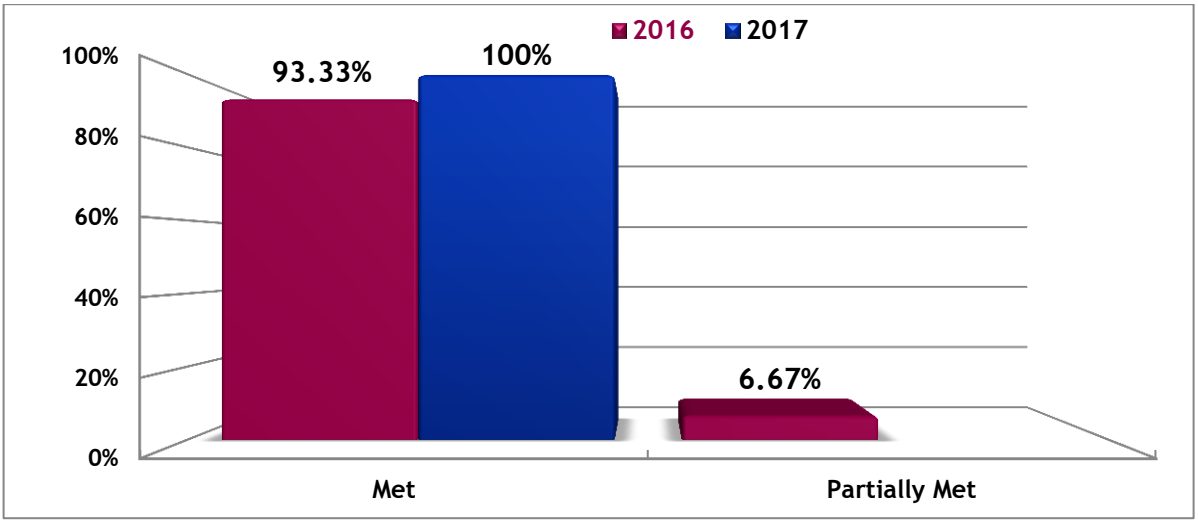


Table 8: Quality Management Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- Both PIPs scored in the High Confidence validation range.

Weaknesses

- There were two discrepancies noted in the *2017 Quality Assessment Performance Improvement Program Description.*
  - Page 10 mentions members and community representatives have opportunities for input into the QI program through efforts of the Community Resource Center. There was no information found in the *Member Handbook* or website of this offered opportunity. This was discussed during the onsite and BlueChoice indicated the Community Resource Centers had been closed.
  - Page 21, under Policies and Procedures Supporting QAPI Programs, indicates that policies and procedures and other materials are reviewed annually and revised when indicated. However, on page 30, under Policies & Procedures, it states policies; procedures and other materials are updated bi-annually.
- There was no quorum established for the SQIC.
- There were a few HEDIS measures that had a decrease of over 10% from last year's rate.

Recommendation

- Correct the 2017 *Quality Assessment Performance Improvement Program Description* to remove the reference to the Community Resource Centers and correct the frequency that policies, procedures and other materials are reviewed and updated.
- Establish a quorum for the SQIC.
- Effort should be made to increase the performance measures that had a drop of more than 10% from last year to this year.

E. Utilization Management

BlueChoice contracts with Amerigroup to provide administrative services for all UM functions. Amerigroup's Health Care Management area includes UM, behavioral health,

case management, maternal-child services, pharmacy management, clinical quality management, and disease management. Amerigroup's 2017 *UM Program Description* has been adopted by BlueChoice and was approved by the CQIC in April, 2017. The *UM Program Description* defines the program's scope, goals, objectives, organizational structure, management responsibilities, staff roles and qualifications, and UM Program components.

Along with the *UM Program Description*, department policies that define UM functions and processes are a resource for staff. The UM Review revealed various discrepancies and errors in policies, as well as other documents including the *Member Handbook* and *Provider Manual*. The discrepancies and/or errors include, but are not limited to, documentation of authorization timeframes and timeframe extensions, sterilization requests, and appeal filing/resolution timeframes. One documentation issue was noted during the previous EQR and remains uncorrected.

MCG Care Guidelines, along with internal medical policies and guidelines, are used to determine medical necessity of authorization requests. Consistency of criteria application is monitored via annual Inter-rater reliability (IRR) testing of staff who issue medical necessity determinations. For 2016, the average IRR score was 95%, an increase of 4 points above 2015 results. Onsite discussion confirmed the benchmark for IRR has recently been increased from 80% to 90%. In addition to annual IRR testing, routine process audits, with a benchmark of 95%, are conducted to evaluate accuracy and consistency of documentation in the UM system. Reports of process audit scores indicate staff consistently exceeds the 95% benchmark. IRR and audit results are reported to the CQIC and SQIC.

BlueChoice has implemented a Preferred Provider Program, as required by the *SCDHHS Contract*, which eliminates prior approval requirements for providers who achieve the Gold Card designation based on historical approval rates of specific procedure codes. Once the designation is achieved, Gold Card providers undergo an annual review to determine the provider's eligibility for continued participation in the program. Currently, one provider group has achieved Gold Card status. BlueChoice continues to evaluate providers for inclusion in the program, and an annual review of the program is conducted to determine if additional procedure codes and provider types will be incorporated into the program.

Review of UM approval, denial, appeal, and case management files confirm that, overall, staff performs processes as required. Denial rationales in initial Notice of Action letters occasionally contained acronyms or abbreviations members may not understand and/or the denial rationale did not clearly convey the reason for the denial decision. Review of appeal files revealed staff are generally compliant with appeal processing and handling requirements. One expedited appeal was inappropriately processed under a standard

timeframe and one appeal resolution letter was sent outside of the required timeframe for notification of resolution. Case management files were thoroughly documented with evidence of appropriate assessments, care plans, monitoring, and follow-up. Overall, the issues noted in the files were limited and did not represent a pattern of deficiencies.

As noted in *Figure 6: Utilization Management Findings*, BlueChoice received "Met" scores for 92.1% of the standards reviewed. Scores of "Partially Met" were related to errors in documentation. One score of "Not Met" is related to an uncorrected deficiency from the previous EQR.

Figure 6: Utilization Management Findings

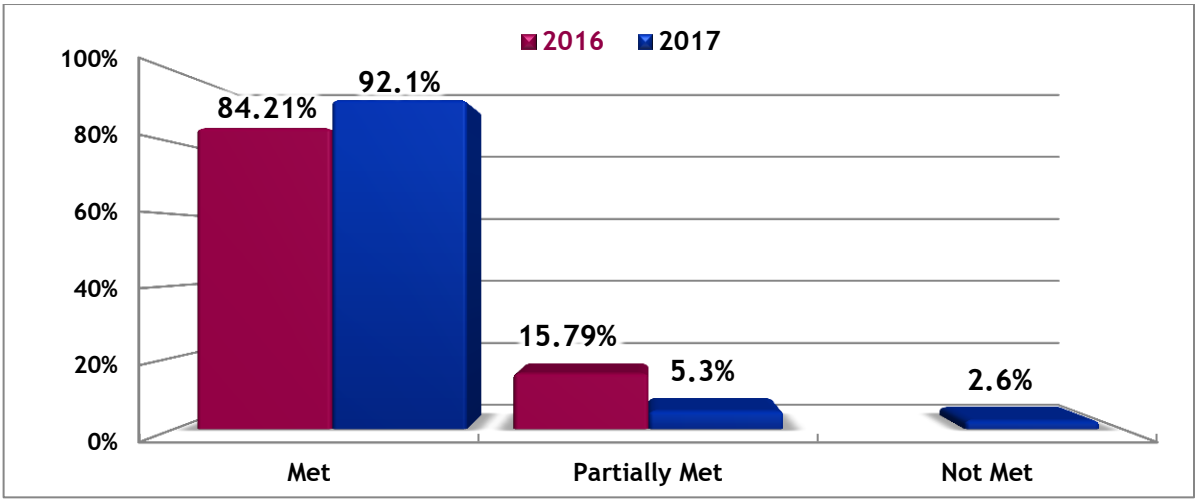


Table 9: Utilization Management Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
The Utilization Management (UM) Program	The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to the mechanism to provide for a preferred provider program	Partially Met	Met
Medical Necessity Determinations	Utilization management decisions are made by appropriately trained reviewers	Partially Met	Met

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Appeals	The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the MCO in a manner consistent with contract requirements, including timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	Not Met
	Other requirements as specified in the contract	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- Staff consistently exceeds benchmarks for IRR and process audit scores.
- In an effort to consider individual member needs in the decision-making process, medical directors review all requests for excluded services and services for which benefits are restricted or exhausted.

Weaknesses

- Documentation of extensions of determination timeframes for urgent, pre-service requests was incorrect in the *UM Program Description* (page 19) and Policy SC_UMXX_117, Decision and Notification Timeframes (page 6).
- The *UM Program Description*, page 35, mentions the Preferred Provider Program but provides no information on the program.
- Policy SC_UMXX_129, Abortions, Sterilizations, Hysterectomies, states the Consent for Sterilization form (SCDHHS form 1723) and a Surgical Justification Review for Hysterectomy form must be submitted for sterilization requests. The *Provider Manual* states only the Consent for Sterilization form is required.
- Policy SC_UMXX_050, Non-physician Review Audits - Process, Inter-Rater, and Focused, does not clearly define the follow-up of IRR scores below the established benchmark.
- Policy SC_UMXX_120, Nurse Inter-Rater, incorrectly defines the nurse IRR benchmark as 80%, which is inconsistent with the benchmark of 90% documented in Policy SC_UMXX_050, Non-physician Review Audits - Process, Inter-Rater, and Focused.
- There appear to be redundancies between Policies SC_UMXX_050 and SC_UMXX_120 which could possibly be eliminated by combining these policies.
- Policy SC_UMXX_078, Physician Inter-rater Reliability Assessment, does not indicate to which committee physician IRR results are reported.

- The *Provider Manual* does not adequately define post-stabilization services and requirements.
- The denial rationale in two initial Notice of Action letters contained acronyms or abbreviations members may not understand. One denial rationale did not clearly convey the reason for the denial decision.
- The *SCDHHS Contract, Amendment Two, Section 9.1.1.2.2*, requires the appeal filing timeframe to be at least 30 calendar days from receipt of the Notice of Action. Onsite discussion confirmed BlueChoice allows appeals to be filed within 90 calendar days from the date of receipt of the Notice of Action. Issues noted with the timeframe to file an appeal include:
    - Policy SC_GAXX_051, Member Appeal Process, page 4, states the appeal filing timeframe is within thirty (90) calendar days from date of receipt of the Notice of Action.
    - The Member Appeal Request Form found on BlueChoice's website states the appeal filing timeframe is within 90 calendar days from the date on the Notice of Action letter.
- A link to the Member Appeal Request form in the *Provider Manual* (page 102) returns the Grievance Request form instead of the Member Appeal Request form.
- Onsite discussion confirmed the expedited appeal resolution timeframe is 72 hours, as stated in Policy SC_GAXX_051, Member Appeal Process, and the *Member Handbook*. However, the *Provider Manual* states the resolution timeframe is 3 business days or 72 hours. This is an uncorrected deficiency from the previous EQR.
- The *SCDHHS Contract, Amendment Two, Section 9.1.4.4.1*, states, "The timeline for the Appeal begins with the receipt of the member's initial notification of appeal (oral or written) to the CONTRACTOR." Additionally, the *SCDHHS Contract, Amendment Two, Sections 9.1.6.1.2* and *9.1.6.1.3,* state the resolution timeframe begins on the day the appeal is received by the plan. For further information, refer to *Federal Regulation § 438.408* and *§ 438.410*. Issues are noted as follows:
    - Policy SC_GAXX_051, Member Appeal Process, does not address date of receipt for appeals received after hours and on weekends. Per BlueChoice staff, the date of receipt for appeals received outside of normal business hours is considered to be the next business day.
    - The "Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid" document (revised June 2016) states the expedited appeal resolution timeframe is within 72 hours "between Monday and Friday".

- Policy SC_GAXX_051, Member Appeal Process, Section K (page 7) addresses the requirement to send standard appeal resolution letters via certified mail; however, Section M (page 8) of the policy does not clearly address the requirement to send expedited appeal resolution letters via certified mail.
- Review of appeal files revealed the following:
    - One expedited appeal was processed under the standard appeal resolution timeframe without medical director review to determine the appropriateness of the expedited request.
    - One appeal resolution letter was sent outside of the required timeframe for notification of resolution. The letter was sent on day 41 after receipt. Onsite discussion confirmed this was an error.

Quality Improvement Plans

- Correct the information regarding extensions of the urgent, pre-service determination timeframe in the *UM Program Description* and Policy SC_UMXX_117.
- Correct the timeframe to file an appeal in Policy SC_GAXX_051, Member Appeal Process, page 4, and on the Member Appeal Request Form.
- Update the link to the Member Appeal Request form in the *Provider Manual* (page 102) to return the correct form.
- Correct the expedited appeal resolution timeframe in the *Provider Manual*, page 103.
- Revise Policy SC_GAXX_051, Member Appeal Process, to address the date of receipt for appeals received after hours and on weekends. Ensure the appeal resolution timeframe begins on the date the appeal is actually received.

Recommendations

- Include a description of the Preferred Provider Program in the *UM Program Description* or refer the reader to the *Preferred Provider Program Description* to obtain additional information.
- Revise the *Provider Manual*, pages 18 and 68, to include the Surgical Justification Review for Hysterectomy form as a requirement for sterilization requests.
- Update Policy SC_UMXX_050 to define the follow-up of IRR scores below the established benchmark.
- Correct the IRR benchmark in Policy SC_UMXX_120 upon the policy's next review and revision.
- Consider combining Policies SC_UMXX_050 and SC_UMXX_120 to eliminate redundancies.

- Include the committees to which physician IRR results are reported in Policy SC_UMXX_078.
- Revise the *Provider Manual* to include complete information on post-stabilization care requirements. Refer to *Federal Regulation § 438.114*.
- Ensure Notice of Action letters are written in language easily understandable by members and clearly convey the reason the request is not approved.
- Revise Section M of Policy SC_GAXX_051, Member Appeal Process, to clearly indicate expedited appeal resolution letters are sent via certified mail.
- Ensure appeals are processed within the appropriate timeframe for the type of request and that appeal resolution notification letters are sent within the required timeframes.

F. Delegation

BlueChoice delegates credentialing functions to Greenville Health Systems (GHS), University Medical Associates (UMA), Vision Service Plan (VSP), and Roper St. Francis. Complex medical case management services are delegated to GHS.

Delegation agreements are in place with all delegated entities, and documentation confirms annual oversight is conducted appropriately. Oversight information and information obtained via routine delegate reporting are provided to appropriate committees, such as the Credentialing Committee, the SQIC, and the QIC.

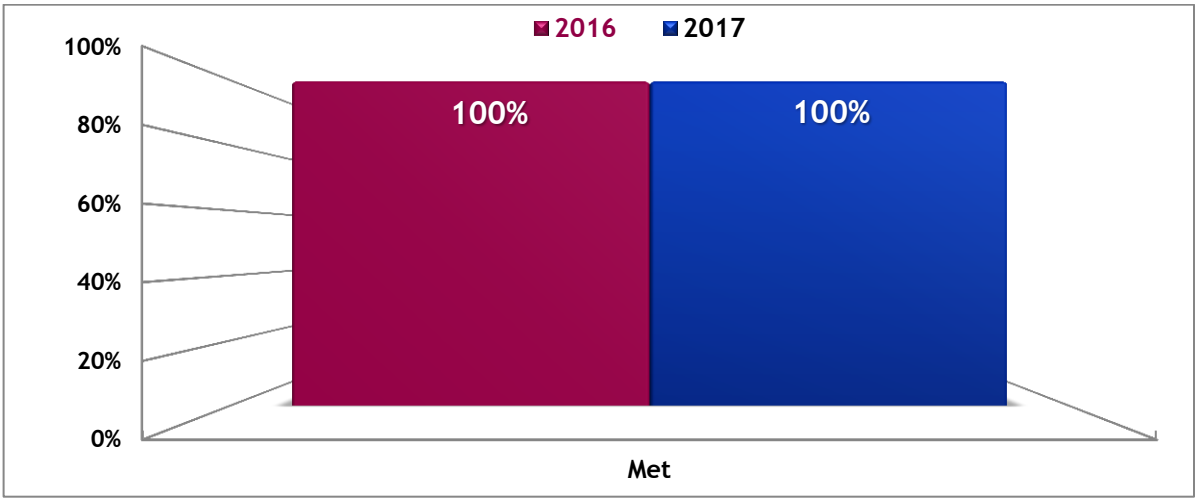
The Credentialing Delegation Agreement template, page two, includes a query of the Excluded Parties List Service (EPLS) administered by the General Services Administration (GSA) as a credentialing and recredentialing requirement; however, the GSA discontinued the EPLS website and now directs users to the System for Award Management (SAM) portal (www.sam.gov). CCME recommended this be updated during the next revision of the Credentialing Delegation Agreement template.

Policies which define pre-delegation processes and oversight requirements for delegates are in place. Credentialing requirements for nurse practitioners (NPs) are not addressed in delegate agreements; however, oversight documentation confirms BlueChoice assesses each applicable delegate's compliance with the requirements for NPs during annual oversight activities.

The 2017 *Case Management Program Description* indicates delegation of case management functions is addressed on page 23 of the document. Examination of the program description, however, confirms delegation of case management is not addressed in the program description.

As indicated in the chart below, 100% of the standards in the Delegation section were scored as "Met."

Figure 7: Delegation Findings



Strengths

- Oversight confirms delegates are compliant with credentialing requirements for nurse practitioners.
- BlueChoice staff worked with VSP to resolve an ongoing issue related to VSP's failure to collect ownership disclosure forms.

Weaknesses

- The table of contents in the 2017 *Case Management Program Description* indicates information addressing delegation of case management functions can be found on page 23 of the program description. However, the program description contains no information regarding delegation of case management functions on the referenced page or elsewhere.
- The Delegation Agreement Template for credentialing, page 2, includes, "Query of the Excluded Parties List Service administered by the General Services Administration" as a credentialing and recredentialing requirement. However, the GSA discontinued the EPLS website and now directs users to the SAM portal (www.sam.gov).

Recommendations

- Revise the *Case Management Program Description* to include information on delegation of case management functions or remove the reference to the information from the table of contents.

- Upon the next revision of the credentialing Delegation Agreement Template, remove the reference to the EPLS as a credentialing and recredentialing requirement.

G. State Mandated Services

Education regarding EPSDT services, including immunizations, is provided through the *Member Handbook*, *Provider Manual*, and by Provider Network Services and Quality Management staff. PCPs receive notice of needed EPSDT services and immunizations through the quarterly *Gaps in Care Report*, and are encouraged to contact members to remind them of needed services. Provider compliance with provision of EPSDT services and immunizations is assessed via random medical record reviews performed by nurse reviewers, and interventions are implemented for providers who score less than 90% on an individual criteria category. Results of the medical record reviews are reported to the CQIC.

Findings of this EQR indicate BlueChoice provides all core benefits required by the *SCDHHS Contract*.

As noted in the chart below, BlueChoice received a score of "Met" for 75% of the standards in the State-Mandated Services section. One standard was scored as "Not Met" due to uncorrected deficiencies from the previous EQR.

Figure 8: State Mandated Services

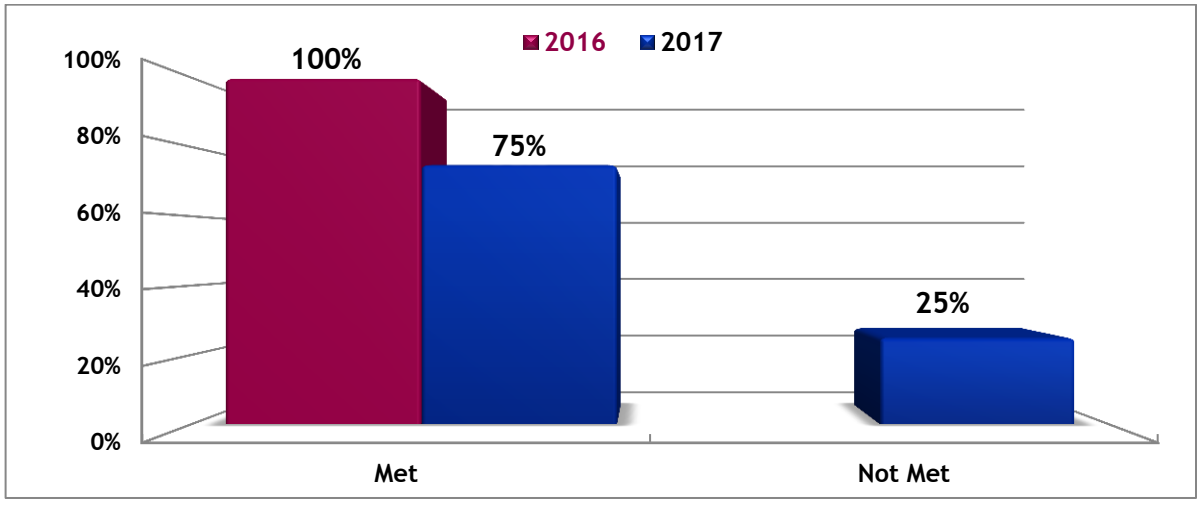


Table 10: State Mandated Services Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
State-Mandated Services	The MCO addresses deficiencies identified in the previous external quality review	Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Weaknesses

- The following deficiencies were noted during the previous EQR and remain uncorrected:
    - Lack of information on the Health Maintenance/Preventive Care appointment access standard of within eight weeks in the *Provider Manual*.
    - Lack of a fax number to the Customer Care Center or Member Services area in the *Member Handbook*.
    - Incorrect expedited appeal resolution timeframe in the *Provider Manual*.

Quality Improvement Plans

- Ensure all deficiencies identified in the EQR are addressed and the corrections are implemented.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

March 13, 2017

Mr. Daniel Gallagher
BlueChoice Health Plan
PO Box 6170, Mail Code AX-400
Columbia, SC 29260-6170

Dear Mr. Gallagher:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2017 External Quality Review (EQR) of BlueChoice Health Plan is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on **May 11th and 12th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **March 27, 2017.**

Submission of all the desk materials will be different than in the past. To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to schedule an education session (via webinar) on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2017

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet and include the practitioner's name, title (MD, NP, PA etc.), specialty, practice name, address, phone number, counties served, if the provider is accepting new patients, and any age restrictions. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization. **Please note this information will be used to conduct our telephone access study.**

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2016 and 2017.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members. Please include committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from September 2016 through February 2017. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract or other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings.

23. A copy of the Grievance, Complaint and Appeal logs for the months of April 2016 through February 2017.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.
35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
    b. reporting frequency and format;

c. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD-9/CPT-4 codes, member months/years calculation, other specified parameters);
d. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
e. denominator calculations methodology, including:
    1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the denominator;
f. numerator calculations methodology, including:
    1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the numerator;
g. calculated and reported rates.

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files made in the months of April 2016 through February 2017. Include any medical information and physician review documentations used in making the denial determination. Please include two behavioral health files and two acute inpatient rehabilitation files.
    d. Twenty-five utilization approval files (acute care and behavioral health) made in the months of April 2016 through February 2017, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at https://eqro.thecarolinascenter.org**
- **and submitted in the categories listed.**

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2017

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied.
2. The file for any member that was involuntarily disenrolled form BlueChoice in the past 12 months.
3. Corporate policies: 65020 and 65019.
4. HIPAA Privacy Operational Requirements" document.
5. Copy of "Our Values" Code of Conduct.
6. Credentialing and utilization management delegation oversight documentation for Companion Benefit Alternatives (CBA).
7. Please provide the following documents that were not received as part of the Credentialing Files or explanation as appropriate:
    a. Michelle M Steffen, MD –Pediatrics: Application states out of state hospital (Piedmont Atlanta Hospital) for clinical privileges but checklist says does not admit. No explanation provided for what she does for admitting patients in SC.
    b. Christopher Stanley, MD -Family Practice: proof of query of the SC Excluded Provider Report.
    c. Three credentialing applications listed active out of state MD licenses in addition to the SC license but did not see proof of license verification. They were for:
        - Christopher Stanley – WI MD license expires 10/20/17;
        - Jennifer Locklear NC MD license expires 7/10/17; and
        - David Barrillo MD active licenses in VA exp. 10/31/18, GA exp. 10/31/18, and PA license with exp. 12/31/16 was active at the time of credentialing.
8. A copy of staff training materials provided to CCC staff regarding grievances and appeals.
9. A copy of policy GBD CM-019: Case Management Program Case Identification.
10. Documents given to new members in the New Member Packet.

C. Attachment 3: EQR Validation Worksheets

- Performance Measure Validation
- Performance Improvement Project Validation
  - Access and Availability of Care
  - Childhood Immunizations Combo 3 and Lead Screenings
- Member Satisfaction Survey Validation – CAHPS Adult
- Member Satisfaction Survey Validation – CAHPS Child

CCME EQR PM VALIDATION WORKSHEET

Plan Name	**Blue Choice**
Name of PM	**ALL HEDIS MEASURES**
Reporting Year	2015
Review Performed	04/2017

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS® TECHNICAL SPECIFICATIONS

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements. Plan contracts with Outcomes Health Information Solutions for medical record abstractions.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements. Plan contracts with Outcomes Health Information Solutions for medical record abstractions.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements. . Plan contracts with Outcomes Health Information Solutions for medical record abstractions.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
S2. Sampling	Sample treated all measures independently.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
R2. Reporting	Was the measure reported according to State specifications?	**NA**	NA

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	5	MET	5
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	0	NA	NA

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and / or accuracy.

Plan's Measure Score	80
Measure Weight Score	80
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PIP Validation Worksheet

Plan Name:	**BlueChoice**
Name of PIP:	**ACCESS AND AVAILABILITY OF CARE (NON CLINICAL)**
Reporting Year:	2016
Review Performed:	2017

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Rate is below the HEDIS 50th percentile.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Question was clearly stated on page 3.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures were defined on page 4.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Indicators are related to process of care and health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	The population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	The relevant population is captured.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**Met**	Sampling relied upon HEDIS specifications.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**Met**	Sampling relied upon HEDIS specifications.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	Sample contained sufficient number of enrollees.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected is documented on page 5.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources are noted on page 5.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is documented on page 5.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data collection will occur once per year, as noted on page 6.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis will be once per year, as noted on page 6.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of personnel are listed on page 5.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions are documented starting on page 11.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	On page 7, rates for baseline are presented, CY 2015.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Partially Met**	The benchmark is lower than the baseline goal (page 7). The baseline goal should be a short-term goal, whereas the benchmark is the long-term goal. **Recommendation:** Adjust documentation of benchmarks so that the benchmark is the highest rate; and the goal rate is higher than the current known rate (goal is the baseline goal).
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline data only.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Follow-up analyses were noted on page 13.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Baseline data only.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Unable to assess.

Component / Standard (Total Points)	Score	Comments
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Unable to assess.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Unable to assess.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline data only.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**Met**	Study findings verified in HEDIS data file.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	5
8.3	1	NA
8.4	1	1
Step 9		
9.1	5	NA
9.2	1	NA
9.3	5	NA
9.4	1	NA
Step 10		
10.1	5	NA
Activity 2	**20**	**20**

Project Score	**113**
Project Possible Score	**118**
Validation Findings	**96%**

AUDIT DESIGNATION
High Confidence in Reported Results

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**BlueChoice**
Name of PIP:	**CHILDHOOD IMMUNIZATIONS COMBO 3 AND LEAD SCREENING (CLINICAL)**
Reporting Year:	2016
Review Performed:	2017

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Rates are below the Nationally Healthy People target rates.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Question was clearly stated on page 3.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures were defined on pages 4 and 5.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Indicators are related to process of care and health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	The population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	The relevant population is captured.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**Met**	Sampling relied upon HEDIS specifications.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**Met**	Sampling relied upon HEDIS specifications.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	Sample contained sufficient number of enrollees.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected is documented on page 5.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources are noted on page 5.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Method of collecting data is documented on page 6.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data collection will occur once per year, as noted on page 6.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis will be once per year, as noted on page 6.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of personnel are listed on page 6.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Interventions are documented starting on page 13.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	On pages 8-9, rates are presented annually, as per the analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Partially Met**	The benchmark is lower than the baseline goal (pages 8-9). The baseline goal should be a short-term goal, whereas the benchmark is the long-term goal. **Recommendation:** Adjust documentation of benchmarks so that the benchmark is the highest rate; and the goal rate is higher than the current known rate (goal is the baseline goal).
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Statistical comparison was documented.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analyses are shown on pages 8-10, and follow up activities are noted on page 15.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Yes, although sampling was adjusted as per HEDIS specifications.
9.2 Was there any documented, quantitative improvement in	**Met**	For Combo 3, the rate increased

Component / Standard (Total Points)	Score	Comments
processes or outcomes of care? **(1)**		initially and then decreased to below the baseline rate. For lead screening, the rate has been increasing from baseline.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**Met**	Improvements appear to be a result of the intervention for Lead Screening; improvements were not shown for Combo 3 in the most recent remeasurement.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Not Met**	Combo 3 does not have statistically significant improvement from baseline, although Lead Screening rates have increased significantly from baseline when compare to remeasurement 2. **Recommendation:** Continue to adapt interventions focused on increasing Combo 3 vaccination rates.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Sustained improvement is unable to be assessed as there are only two remeasurement periods, and improvement was not noted for one of the measures.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**Met**	HEDIS rates verify the rates documented in PIP.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	5
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	0
Step 10		
10.1	NA	NA
Activity 2	20	20

Project Score	125
Project Possible Score	131
Validation Findings	95%

AUDIT DESIGNATION
High Confidence in Reported Results

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR Survey Validation Worksheet

Plan Name	**BLUECHOICE**
Survey Validated	**CAHPS ADULT**
Validation Period	2016
Review Performed	04/2017

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation:*2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. Blue Choice had a sample size of 1,777. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, and are clear and appropriate. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate was 28.5%. The target response rate according to NCQA is 40.0%. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research* *Recommendation: Implement strategies to increase response rates such as website or email announcements, bulletin postings, call center script additions that remind members of the survey, placing stamps on survey envelopes, and incentives for members.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan was in place. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - DSS Research as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 28.5%. The target response rate according to NCQA is 40.0%. CCME recommends using caution when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	The plan scored below the ANM Average for 2016 on Getting Needed Care. The plan scored above the ANM Average for 2016 on Customer Service, Getting Care quickly, How Well Doctors Communicate, and Shared Decision Making. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research.*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	There is no documentation of results being reported to members. Upon review of the website, the most recent results were 2014 CAHPS results: http://www.bluechoicesc.com/UserFiles/bluechoice/Documents/Everybody/2014%20CAHPS_KAS.pdf.
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *2016 CAHPS Member Survey Adult Medicaid Report prepared by DSS Research*

CCME EQR Survey Validation Worksheet

Plan Name	**BLUECHOICE**
Survey Validated	**CAHPS CHILD**
Validation Period	2016
Review Performed	04/2017

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation:*2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was clearly defined. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Sample frame was clearly defined. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	BlueChoice had a sample size of 2,182. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, and are clear and appropriate. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate was 23.37%. The target response rate according to NCQA is 40.0%. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research* *Recommendation: Implement strategies to increase response rates such as website or email announcements, bulletin postings, call center script additions that remind members of the survey, placing stamps on survey envelopes, and incentives for members.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan was in place. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - DSS Research as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 23.37%. The target response rate according to NCQA is 40.0%. CCME recommends caution when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	The plan scored below the ANM Average for 2016 on Customer Service. The plan scored above the ANM Average for 2016 on Getting Needed Care, Getting Care quickly, How Well Doctors Communicate, and Shared Decision Making. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	There is no documentation of the CHILD results being reported to members. Upon review of the website, the most recent results were 2014 CAHPS results: http://www.bluechoicesc.com/UserFiles/bluechoice/Documents/Everybody/2014%20CAHPS_KAS.pdf.
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *2016 CAHPS Member Survey Child Medicaid Report prepared by DSS Research*

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	**BlueChoice HealthPlan of SC**
Collection Date:	2017

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Onsite discussion confirms BlueChoice conducts annual reviews on all policies and procedures. Policies are organized in a consistent manner. The responsibility for annual review has shifted to the BlueChoice HealthPlan Corporate Compliance Committee. The process for annual review, revision, and the committee with the responsibility for policy review was not found. NCQA Accreditation was completed in 2015. *Recommendation: Document in a*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						policy/procedure or other format the staff or committee responsible for policy reviews and revisions, and the process for conducting the reviews annually.
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						BlueChoice and Anthem/Amerigroup have sufficient resources and staff to ensure the delivery of all required care and services to members.
1.1 *Administrator (CEO, COO, Executive Director);	X					Tim Vaughn is president and COO for BlueChoice HealthPlan Medicaid. Dan Gallagher serves as vice president and is responsible for the day-to-day business activities. They are both located in South Carolina.
1.2 Chief Financial Officer;	X					Jennifer Thorne is the chief financial officer.
1.3 * Contract Account Manager;	X					Onsite discussion confirmed that Dan Gallagher serves as contract account manager. The organizational chart does not clearly identify Dan Gallagher in this position. *Recommendation: Update the organization chart as noted.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Information Systems personnel;						Thomas Miller is senior vice president and chief information officer.
1.4.1 Claims and Encounter Manager/Administrator,	X					Pamela Monihan is staff vice president for claims. Christopher Kearney is claims director II, located in Virginia. Onsite discussion confirmed claims are processed in Virginia and California.
1.4.2 Network Management Claims/Encounter Processing Staff,	X					Dale Rish serves as vice president of contracting and reimbursement and Scott Timmons is the senior director provider network and Medicaid contracting. Oversight for encounter processing includes Kerris Haynes, staff vice president of operations and execution. Providers and members with questions regarding claims are directed to appropriate staff via the Customer Call Center (CCC).
1.5 Utilization Management (Coordinator, Manager, Director);	X					Victoria McNeil Brock is the director of CM/UM and is located in SC. She is supported by managers in case management, prior authorization, and concurrent review. Maureen Daniels is medical manager over prior authorization and concurrent review and Michael Brownlee is manager for case management.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5.1 Pharmacy Director,			X			Express Scripts (ESI) is the Pharmacy Benefit Manager for BlueChoice Medicaid. Suzanne Trautman is listed on the organization chart as the regional pharmacy account director, located in NC, and available to BlueChoice to answer pharmacy related questions. Ms. Trautman is a PharmD and a Pharmacist; however, she is not found on the SC or NC Board of Pharmacy registries as a licensed pharmacist due to an expired license. According to the *SCDHHS Contract, Exhibit 1*, the pharmacy director must be appropriately licensed as a pharmacist in the state in which they operate. *Quality Improvement Plan: Ensure the pharmacy director meets the contract requirements. Describe the process used to verify licensure for the pharmacist and other staff requiring licensure and ensure the process is being followed.*
1.5.2 Behavioral Health Coordinator,	X					Wendy Graham, LPC, serves as manager of behavioral health services. She oversees 2 case managers, 3 care managers, and 1 behavioral health outreach specialist. Several policies and procedures related to behavioral health were submitted upon request during the onsite. BlueChoice has a board certified psychiatrist available for oversight and development of the Behavioral Health Program. Dr. Smithey is licensed in the states of Florida and Kentucky and is in the process of obtaining South Carolina

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						licensure. See the *SCDHHS Contract, Section 2, Exhibit 1 (July 2016)* for details of the requirement for this position. *Recommendation: Ensure BlueChoice is compliant with contract requirements for a board certified, SC-licensed psychiatrist.*
1.5.3 Utilization Review Staff,	X					Sufficient staff is available to conduct prior authorization, concurrent review, and case management utilization functions.
1.5.4 *Case Management Staff,	X					Sufficient staff for medical and behavioral health case management are located in SC.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					The quality manager position is vacant and the director of clinical quality management position was recently vacated. Onsite discussion revealed temporary staff is in place. *Recommendation: BlueChoice is encouraged to fill 2 vacant quality positions with qualified staff as soon as possible.*
1.6.1 Quality Assessment and Performance Improvement Staff,	X					Staffing in this area consists of a HEDIS coordinator and abstractors, program administrators, and a reporting specialist. Health program representatives support quality functions in the Provider Services area.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 *Provider Services Manager;	X					Martha Owens is the assistant vice president of healthcare services. Amy Bennett is the director, Medicaid operations for BlueChoice and Scott Timmons is the senior director of provider network and Medicaid contracting.
1.7.1 *Provider Services Staff,	X					Shay Looker is the manager of provider relations.
1.8 *Member Services Manager;	X					Gary Ries is the director for Medicaid field operations, is located in South Carolina, and is responsible for the oversight of 20 functional areas, including the Customer Care Center. Director I of Customer Care, Gordon Schleffer, is located in Florida and Iesha Young is manager of customer care. The member call center and Ms. Young are located in Savannah, Georgia. Donna Williams is located in SC and is the manager of community relations and SC sales and marketing.
1.8.1 Member Services Staff,	X					A total of 16 customer care representatives work in the CCC. In addition there is an outreach specialist and community relations staff.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 *Medical Director;	X					Dr. Imtiaz Khan serves as medical director, and is located and licensed in SC in family practice. Onsite discussion confirmed Dr.Lloyd Kapps is the medical director on the Credentialing Committee, and Dr. Molly Matthews (pediatrician) is available 30 hours per week. The *UM Program Description* includes the medical directors' involvement with the following: •Improving practitioner relationships through increased medical director involvement and peer-to-peer conversations •Involvement with MPTAC •Implementation and development of the UM Program •Development and oversight of behavioral healthcare aspects of the UM Program It also discusses the role of Amerigroup and corporate medical directors, including quality.
1.10 *Compliance Officer;	X					Rod Johnson is the BlueChoice compliance officer and privacy officer, and is located in SC. He reports directly to the president and COO and to Andre Acosta, Medicaid plan compliance director. Debra Teeter is the program integrity coordinator/senior investigator. Reporting structure includes David Collins, manager of investigations and the Director of Special Investigations, Jen DePaul.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.11 * Interagency Liaison;	X					Dan Gallagher serves as the interagency liaison.
1.12 Legal Staff.	X					Melanie Joseph is legal counsel in SC.
2. Operational relationships of MCO staff are clearly delineated.	X					The reporting structure is demonstrated in the organization chart and staff members appear to function within this structure.
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all MCO staff positions.	X					The licensure and educational requirements for utilization functions are detailed in program descriptions for CM, UM, and Disease Management. The requirements for all staff positions are detailed in job descriptions.
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					The Information System Capabilities Assessment (ISCA) audit documentation states that claims are monitored for timeliness and accuracy. BlueChoice meets the organization's internal requirements and surpasses the *SCDHHS Contract* requirements by completing 98% of claims in 30 days and 99% within 90 days. Information regarding the updates or improvements made to the Medicaid claims systems were provided and reviewed.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					The transaction processing systems verify enrollee uniqueness by using a SCDHHS assigned number. Documentation provided indicates that the IT solutions for the BlueChoice have the capability to track enrollees' data across multiple internal systems.
4. The MCO management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					BlueChoice demonstrates that Anthem has documented the safe computing practices needed to protect the systems and data used to service the MCO contract. In September, 2015 an approved HITRUST CSF Assessor validated and confirmed that the work was performed in accordance with, and meets, the 2015 HITRUST CSF Certification Criteria. This assessment is good for two years.
7. The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					The documentation provided business continuity documentation and the latest updated revision of its disaster recovery guide. Detailed results of Anthem's June, 2016 disaster recovery exercise and its results were provided, as well as any required revisions to the plan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I D. Compliance/Program Integrity						
1. The MCO has policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse.	X					BlueChoice has a Medicaid Compliance Plan (dated December 1, 2016), a Fraud and Abuse Program Integrity Plan (not dated but onsite discussion confirmed it was updated on the same date as the Compliance Plan), and multiple policies and procedures detailing Federal and State requirements for compliance and program integrity. The compliance officer receives annual training. Members and providers are given information on reporting fraud, waste or abuse and a hotline to contact in the *Member Handbook* and the *Provider Manual*. Annual review of HIPAA, compliance, Federal False Claims Acts, and fraud, waste, and abuse is required for employees and subcontractors. Training is conducted electronically and in person and successful completion is tracked. BlueChoice conducts data analysis and data mining to identify outliers, potential errors, areas of risk and establish a baseline to recognize trends and identify fraud, waste and abuse. *Recommendation: Ensure the date of the last update or review of the Fraud and Abuse Program Integrity Plan appears on the*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						document.
2. The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.		X				The Compliance Committee Charter states the committee shall meet on a monthly basis, but no fewer than 4 times per year. Committee minutes indicate a quorum is present and there is good attendance at these meetings. The charter is dated 2015. The membership list in the Compliance Committee Charter is not consistent with the submitted Committee Membership list. *Quality Improvement Plan: Update membership lists for the Compliance Committee in the committee charter and committee membership list to be in agreement with each other.*
I E. Confidentiality						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy MCD-09, Privacy and Confidentiality states, "BlueChoice adopts corporate BCBS policies to maintain privacy and confidentiality of PHI and a secure environment in which to work." Physician offices are monitored to ensure medical records are stored and protected. The provider has policies for his/her staff on privacy and confidentiality. BlueChoice policies guide the proper release of information and the data safeguards in place. Members are provided the Notice of Privacy Practices (NPP) in the *Member Handbook* upon enrollment and reminders to heads of households every 3 years as required. Employees are required to undergo "Our Values" training within 30 days of hire. Onsite discussion concluded that new employees are trained in privacy and confidentiality prior to access to PHI; however, this is not found in any document, policy, or the HIPAA Privacy Operational Requirements document, page 31. *Recommendation: Update Policy MCD-09, Privacy and Confidentiality to include HIPAA training is conducted prior to any access to PHI. The American Health Information Management Association (AHIMA) recommends this best practice guideline.*

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.		X				BlueChoice's credentialing program is well-defined and processes are described in the *Medicaid Credentialing Program Plan* and several policies. Initial credentialing is addressed in Policy MCD-04 and recredentialing is addressed in Policy MCD-05. Policy MCD-06, Health Care Delivery Organization – Credentialing/Recredentialing, addresses delivery organizations. For behavioral health, Companion Benefit Alternatives (CBA) provides the benefits on behalf of BCBS and BlueChoice. The BlueChoice credentialing department performs the credentialing and recredentialing activities for CBA. A few issues were noted in the *Medicaid Credentialing Program Plan* as follows: •Section VI. A. does not address that queries are performed for the Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE) and the SC Excluded Provider List. •Section IV. B. does not mention collection of the Disclosure of Ownership form or queries performed for organizational providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						At the onsite BlueChoice indicated they were in the process of implementing a query of the Social Security Death Master File (SSDMF) in to the credentialing/ recredentialing process. *Quality Improvement Plan: Update the Medicaid Credentialing Program Plan to include all queries performed for physicians and organizational providers, and the collection of ownership disclosure forms for organizational providers.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					The Medical Director, Dr. Lloyd Kapp, chairs the Credentialing Committee and has primary responsibility and oversight for all the credentialing activities, including the approval of policies and procedures. Additional committee members include the vice president of medical affairs and nine network providers with specialties including internal medicine; pediatrics; chiropractic; surgery; pulmonology; OB/GYN; and dental. Only network providers on the committee have voting privileges and a quorum is met with three network providers in attendance at each meeting. The Credentialing Committee reviews of "clean files" are conducted on a weekly basis, and focused reviews of "unclean files" occur bi-monthly. A review of committee minutes showed detailed discussion and a quorum was met at each meeting. For behavioral health practitioners, the Companion Benefit Alternative (CBA) Credentialing Committee has the responsibility for the credentialing/

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						recredentialing decisions.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Credentialing files were in good order and contained appropriate documentation.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS Certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); State Excluded Provider's Report;	X					
3.1.10 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.11 In good standing at the hospitals designated by the provider as the primary admitting facility. (hospital privileges/coverage plan);	X					
3.1.12 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.1.13 Ownership Disclosure form .	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.	X					Policy MCD-02, Medical Office Pre-Contracting Site Review, states that BlueChoice assesses the quality, safety, and accessibility of office sites where care is delivered. A pre-contracting site review for PCPs, OB/GYNS, and high-volume behavioral health care providers is conducted before initial credentialing of the first provider at a practice site. Also, site visits are conducted when a new office site is opened or when a provider relocates to another site. The performance goal is 90% per site visit. Credentialed practices whose site visit score is below 90% receives a recommendation for a CAP with follow up within six months. Evidence of site reviews was presented in the credentialing files.
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Recredentialing files were in good order and contained appropriate documentation.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of Service System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); State Excluded Provider's Report;	X					
4.2.9 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.10 In good standing at the hospitals designated by the provider as the primary admitting facility. (hospital privileges/coverage plan);	X					
4.2.11 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.12 Ownership Disclosure form.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.3 Site reassessment if the provider location has changed since the previous credentialing activity.	X					Policy MCD-02, Medical Office Pre-Contracting Site Review, states that BlueChoice follows NCQA requirements regarding site visits initiated as a result of complaints on the physical accessibility, physical appearance, or adequacy of waiting and examining room space of the offices of network providers. Quality management conducts a site visit each time a medical office exceeds the complaint threshold. The complaint threshold is three complaints received per office in a single complaint category as follows: physical accessibility of the office, physical appearance of the office, and adequacy of waiting- and examining-room space. The site visits are conducted within 45 calendar days of receipt of the last complaint that met the threshold for a complaint-triggered site visit.
4.4 Review of practitioner profiling activities.	X					BlueChoice utilizes provider performance reports such as the monthly *Gaps in Care Report*; *Membership Loss Ratio By Practice*; monthly *ER Diversion* report; and HEDIS measures reports to educate providers. Provider profiling information regarding sanctions, member complaints and quality issues are considered in the recredentialing process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Policy SC GASS_021, Clinical Quality Incident Severity Level Determination, states that Amerigroup PP has an electronic data tracking system in place to investigate, evaluate and assign a severity level to network physicians for member clinical grievances, administrative grievances (quality of service), and internal potential quality issue cases. The policy defines the procedures along with review and/or action taken by the Medical Director. Policy MCD-07, Professional Practitioner – Restriction, Suspension or Termination, defines the process used to restrict, suspend, or terminate participating practitioners based on issues of quality of care, quality of service, or credentialing. Providers are offered appeal rights, and outcomes of investigations are reported to appropriate outside agencies.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.		X				The credentialing/recredentialing process for organizational providers is defined in Policy MCD-06, Health Care Delivery Organizations – Credentialing/Recredentialing. However, the policy does not address what queries are performed or the collection of the Disclosure of Ownership form. *Quality Improvement Plan: Update Policy MCD-06, Health Care Delivery Organizations - Credentialing/Recredentialing to include the queries that are performed and the collection of Disclosure of Ownership forms.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.		X				BlueChoice queries approved state and federal sources for sanction information on a monthly basis as defined in Policy MCD-07, Professional Practitioner- Restriction, Suspension or Termination, and Policy MCD-03, Ongoing Monitoring of Sanctions. Policy SC_PNXX_309, Excluded and Debarred Providers – BlueChoice, discusses monitoring at initial cred and monthly for excluded and debarred providers, but the list of queries is different than what is listed in Policy MCD-07. Onsite discussion revealed that Policy SC_PNXX_309 is an Amerigroup PP policy that may duplicate processes already addressed in Policy MCD-07. BlueChoice indicated they may retire Policy SC_PNXX_309. *Quality Improvement Plan: Address inconsistencies in Policies MCD-07 and SC_PNXX_309 regarding the queries performed and the process of monthly provider monitoring. If Policy SC_PNSS_309 is retired, ensure that MCD-07 is updated to address all queries and the monthly provider monitoring process being performed.*
II B. Adequacy of the Provider Network						
1. The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					BlueChoice measures the access standard for primary care providers as one PCP within 30 miles for 95 percent of the population as defined in Policy MCD-11, Medicaid Access/Availability Standard. PCPs are considered as family practitioners/general practitioners, pediatricians, and internists. GEO Access reports reflected that PCP measures complied with the policy and contract requirements: 100% of members have access to one PCP within 30 miles.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy MCD-11, Medicaid Access/Availability Standard, defines the access standard for high volume specialists as one specialist within 50 miles; one OB/GYN within 30 miles; one hospital within 50 miles; and one pharmacy within 30 miles for 95% of the population. The *BlueChoice HealthPlan of South Carolina Medicaid 2016 Medicaid Availability Analysis for PCPs & High Volume Specialists* report reflected high volume specialists include the categories of OB/GYNs, cardiologists, ENTs, urologists, general surgeons, orthopedists, and oncologists/hematologists. Results showed the 95% goal was met: 100% member access in all categories except for OB/GYN which was 99.9%. The hospital and pharmacy categories reflected 100% member access as well. The *BlueChoice HealthPlan of South Carolina Medicaid 2016 Medicaid Availability Analysis Behavioral Health Practitioners* report included availability analysis for behavioral health. The

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						distribution of behavioral health practitioners includes psychiatrists, psychologists, and social workers/licensed professional counselors which are measured as one practitioner within 50 miles for 95% of members. Results showed the psychologist category met 99.8% of members while the psychiatrist and social workers/licensed professional counselors categories scored 100% member access.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					BlueChoice submits GEO Access reports to SCDHHS bi-annually as required and measures access and availability standards at least annually as defined in Policy MCD-11, Medicaid Access/Availability Standard. In addition, ad-hoc GEO Access reports are run regularly to assess business needs.
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					BlueChoice ensures culturally and linguistically appropriate health care services to all members as defined in Policy CLLS-018, Cultural and Linguistic Program. The *BlueChoice HealthPlan of South Carolina Medicaid 2016 Cultural Needs Assessment* was conducted to evaluate BlueChoice's network physicians in meeting the member's cultural, racial, ethnic and linguistic needs. Multiple sources are used in the evaluation to include member complaints, demographic/linguistics and CAHPS member survey data. Results showed there were no complaints related to a lack of culturally diverse physicians, and no complaints during the 2015

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						review period in regards to language, ethnicity/ culture or race categories. There were 15 requests made for face-to-face interpreter services; all requests were for a Spanish interpreter and there were no TTY calls received by the SC Customer Care Center. Interpreters are available 24/7 with face-to-face support provided via CulturaLink.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					BlueChoice maintains a detailed website provider search that allows the user to print a directory directly from the website. They also provide copies of a printed directory upon request.
3. Practitioner Accessibility						
3.1 The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				The following issues/inconsistencies related to appointment accessibility were identified: • Physician office accessibility standards are defined in Policy MCD-11, Medicaid Access/ Availability Standards. The policy states a 4 – 6 week appointment standard for routine care appointments; however, the *Provider Manual* and the 2016 provider education presentation state a 4-week timeframe. In addition, the 2016 QAPI Annual Evaluation shows the 4-week timeframe for routine care appointments as being measured. •The presentations (Overview for Physicians-Feb. 2015 & Overview for Facilities-Feb. 2015) loaded to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Education, Training and Resources section of the website states that routine care is "within 4 – 6 weeks." The presentations also mention a standard of "sick care appointment within three days of presentation" that is not mentioned in Policy MCD-11 or the *Provider Manual*. These presentations should be updated since they are posted to the website. • In the previous EQR, BlueChoice indicated they would add the following appointment standard to the *Provider Manual*, "Health Maintenance/ Preventive Care: within 8 weeks" since this was a standard being measured by the plan. However, the information does not appear in the *Provider Manual* received in the desk materials. • BlueChoice measures appointment availability and after hour's access through a number of different methods. Onsite discussion confirmed they assess individual provider appointment availability through calls to provider offices; however, the information did not appear to have been reported. Two reports received in the desk materials (the *BlueChoice HealthPlan Medicaid Practitioner Access Analysis* report (2015) and the *2016 QAPI Program Evaluation* stated a practitioner-level review was conducted during 13 practitioner onsite visits; however, results of the study were not reported. The reports did include the appointment standards that were used for the evaluation. The reports indicated the urgent care standard "within 24 hours" was measured; however, Policy MCD-11 and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the *Provider Manual* define the urgent care standard as "within 48 hours." When asked onsite to provide results of the practitioner level review, BlueChoice provided a revised copy of the *BlueChoice HealthPlan Medicaid Practitioner Access Analysis* report (2015). Also provided was an email (dated May 22, 2017) that indicated the standard for urgent care had been changed from "within 24 hours" to "within 48 hours." It was unclear why the report was changed during the onsite and which urgent care standard had been measured. *Quality Improvement Plan: Update Policy MCD-11, Medicaid Access/Availability Standards, to reflect a 4-week timeframe for routine care appointments. Update the 2015 provider training presentations on the website to accurately reflect the appointment standards. Update the Provider Manual to reflect the "Health Maintenance/Preventive Care" standard that was identified in the previous EQR. Ensure measurement for the urgent care appointment standard reflects the "within 48 hours" standard being communicated to providers.*
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.			X			In reference to the results of the *Telephonic Provider Access Study*, conducted by CCME, calls were successfully answered 45% of the time (141/311) by personnel at the correct practice, which estimates between 43 and 48% for the entire population using a 95% confidence interval. When

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						compared to last year's results of 53%, this year's study had a statistically significant decrease in successfully answered calls (Z=2.03, p=.04). *Quality Improvement Plan: Regarding member's access to their providers, identify and address barriers in the update process so that having up-to-date contact information for members is not an issue.*
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					New provider orientation is scheduled with each office when a new provider contract is signed as defined in Policy MCD-01, Education of Contracting Providers. The new provider orientation training covers various topics and is conducted by the BlueChoice Medicaid Provider Education Department.
2. Initial provider education includes:						The *Provider Manual* is a good resource document as well as other educational and reference information on the provider portal of the BlueChoice website. A few issues are discussed in the following section.
2.1 MCO health care program goals;	X					
2.2 Billing and reimbursement practices;	X					Provider training on fraud, waste, and abuse was conducted September 2016.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;		X				There are inconsistencies in "no copay" and benefit information listed in the *Provider Manual* (page 15), *Member Handbook* (page 10), and the copay information page of the website: •"EPSDT well-child visits/services" is listed in the *Provider Manual* and not in the *Member Handbook* or website. •"Rehabilitative behavioral health services" is listed in the *Member Handbook* and not the *Provider Manual* or the website. •"No prescription copay" for family planning medicine, smoking cessation drugs, behavioral health drugs and certain diabetic medications is listed in the *Provider Manual* and *Member Handbook* but not on the website. •"Outpatient Services" (*Provider Manual*, page 22) lists a $3.30 copay but the *Member Handbook* and website state a $3.40 copay. •"Psychiatric Assessment Services" (*Provider Manual*, page 25) states a one assessment limit per member every 12 months but the *Member Handbook* (page 20) states every 6 months. Onsite discussion confirmed it should be every 6 months. *Quality Improvement Plan: Correct the member benefit discrepancies identified between the Provider Manual, Member Handbook, and the BlueChoice website.*
2.4 Procedure for referral to a specialist;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					Per onsite discussion, BlueChoice educates providers to use a PCP change form if a member is interested in changing their PCP. However, this information is not listed in the *Provider Manual*. *Recommendation: Update the Provider Manual to include instructions on how to reassign a member to another PCP.*
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Provider education is addressed in Policy MCD-01, Education of Contracting Providers. Health Network Services is primarily responsible for provider education which takes place through performing on-site orientations, providing educational materials and references, updating the providers through the use of the web and special meetings, annual workshops, and routine-onsite contacts.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II D. Primary and Secondary Preventive Health Guidelines						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Preventive Health Guidelines (PHGs) are developed, adopted and revised to ensure that preventive health programs incorporate current, evidence-based guidelines from nationally-recognized sources. The guidelines are reviewed and approved locally by the CQIC. Policy SC_PCXX_006, Preventive Care, defines the process for review, adoption, distribution and performance monitoring, developed by Amerigroup on behalf of BlueChoice Medicaid. The *2017 Quality Assessment Performance Improvement Program Description* has an outdated statement on page 27 as follows, "After internal review, changes recommended for 2014 will be presented to the CQIC for approval and adoption." *Recommendation: Correct the following outdated statement on page 27 of the 2017 Quality Assessment Performance Improvement Program Description, "After internal review, changes recommended for 2014 will be presented to the Clinical Quality Improvement Committee (CQIC) for approval and adoption."*
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Preventive health guidelines are posted on the member and provider websites. Members are made aware of preventive health guidelines in the *Member Handbook* and/or newsletters. Providers

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						are notified of the availability of the preventive health guidelines in the *Provider Manual*. A written copy of the guidelines is also available upon request.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups.	X					
4. The MCO assesses practitioner compliance with preventive health guidelines through direct medical record audit and/or review of utilization data.	X					The *2016 Quality Assessment Performance Improvement Program Evaluation* states the plan monitors compliance with clinical practice and preventive health guidelines through HEDIS and onsite medical record review. Policy SC_PCXX_006, Preventive Care, states the provision of preventive services is monitored through medical record review, with results reported to the CQIC at least annually.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The MCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					All clinical practice guidelines (CPG) are from nationally recognized and evidence-based organizations and/or societies. The CPGs, including behavioral health guidelines and preventive health guidelines are reviewed at least annually or more frequently, when clinical evidence changes, by the CPG/PHG Workgroup. After approval by QIC, these are taken to the local CQIC for approval and adoption at the local health plan level. Policy SC QMXX-048, Clinical Practice Guidelines Review, Adoption, and Distribution, defines the process of adoption, review and approval of clinical practice guidelines for medical and behavioral health, developed by Amerigroup on behalf of BlueChoice Medicaid.
2. The MCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for MCO members to providers.	X					Clinical practice guidelines are addressed in the *Provider Manual* and are loaded to the BlueChoice Medicaid website. A written copy of the guidelines is also available upon request. Newly contracted providers are educated through their welcome materials.
3. The MCO assesses practitioner compliance with clinical practice guidelines for disease and chronic illness management through direct medical record audit and/or review of utilization data.	X					Policy SC QMXX-048, Clinical Practice Guidelines Review, Adoption, and Distribution, states that annually Amerigroup PP measures performance against at least two important aspects of the practice guidelines.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					Policy SC QMXX-080, Monitoring Continuity and Coordination of Medical Care, states the continuity and coordination of care is monitored to determine the extent of communication with PCPs and hospitals, home health agencies, skilled nursing facilities, and ambulatory surgical centers. BlueChoice Medicaid annually monitors continuity and coordination of medical care and takes action as appropriate to improve coordination of care. The *2016 Quality Assessment Performance Improvement Program Evaluation* states the behavioral health program continues to integrate the care of the members with co-morbid behavioral and medical problems. The behavioral health team, medical teams, and staff from the disease management programs share the same medical information system and medical case managers refer members to behavioral health for coordination of care.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					The Quality Management department conducts medical record reviews to assess PCP compliance with medical record standards as defined in Policy MCD-12, Medical Record Review for Documentation Standards. Information regarding medical record review criteria is listed in the *Provider Manual*. Policy SC QMXX_105, Medical Record Review, also

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						details the medical record review process.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Policy MCD-12, Medical Record Review for Documentation Standards, defines the process for conducting provider medical record reviews for all PCP offices with a minimum of 100 members or during the Gaps in Care onsite reviews, if one has not previously been performed at the location. Sites scoring below the 80% cumulative score are mailed a letter explaining their deficiencies. A corrective action plan is developed and a follow-up visit is conducted within six months. The 2016 Medical Record Review (MMR) was conducted for 12 groups (89 practitioners) with a total of 165 medical records reviewed. The overall score was 97% which was an increase of 2% over the 2015 MMR. One group fell below the 80th percentile in the continuity of care and three were below the 80th percentile in the preventive categories. Action was taken by educating the providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
1. The MCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Policy SC_QMXX_104, Member Rights and Responsibilities, the *Member Handbook*, the BlueChoice website, and *Provider Manual* include the rights and responsibilities as defined in the *SCDHHS MCO Contract*. Methods of informing members include the *Member Handbook*, Newsletters, and the website.
2. Member rights include, but are not limited to, the right:	X					Member rights are included consistently across plan documentation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 To be treated with respect and dignity;						
2.2 Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation;						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and it providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Members are informed in writing within 14 business days of enrollment of all benefits to which they are contractually entitled, including:			X			Policy SC_COXX_126, Annual Notification to Members, states BlueChoice is committed to ensuring members receive all written materials telling them about their health plan. New members are provided an Evidence Of Coverage (*Member Handbook*) upon enrollment. Onsite discussion also confirmed BlueChoice continues to supply Provider Directories to new members and upon request. Policy MCD-09, Privacy and Confidentiality, states the Notice of Privacy Practices are found in the *Member Handbook* and mailed within 14 days of enrollment. It is not documented in policy or procedure that *Member Handbook*s are supplied within 14 days of enrollment. Reference the *SCDHHS Contract* (dated 2014), *Section 3.12.2 and 3.12.6,* or the 2016 *SCDHHS Contract, Section 3.15.3,* which state member education materials are sent no later than 14 calendar days from the receipt of enrollment data. *Recommendation: Include in Policy MCD-09 or a different policy or procedure that members are sent Member Handbooks and member educational materials no later than 14 calendar days from the receipt of enrollment data.* The score of "Not Met" is due to an uncorrected deficiency in the standards below.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Full disclosure of benefits and services included and excluded in their coverage;						The *Member Handbook* informs members about benefits and services provided by their coverage. The *Member Handbook* states member rights include receiving information about the health plan service area; however the service area is not found in the *Member Handbook*. See page 76 of the *Member Handbook* and reference *Federal Regulation § 438.10 (e) (2) (iv)*. *Quality Improvement Plan: Update the Member Handbook to include the service area covered by BlueChoice.*
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						Second opinions are only addressed in the glossary section of the *Member Handbook*. The information provided meets the requirement of the contract; however, members are not likely to go to the glossary to find it. *Recommendation: Include information about second opinions with benefit information in the body of the Member Handbook.*
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Any applicable deductibles, copayments, limits of coverage, maximum allowable benefits and claim submission procedures;						The BlueChoice *Member Handbook* includes a table and narrative description of available services. Copayments are addressed in the handbook, the *Provider Manual*, and on the website. BlueChoice is developing a secure portal for members that will enable members to send secure emails to the plan and access additional education on various health topics.
1.4 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The *Member Handbook* includes good information for members about routine, emergency, and urgent services and how to obtain them. Over utilization is tracked by claims and members who are identified as possible over utilizers are offered case management for further education and assistance obtaining services in a cost-effective manner.
1.7 Procedures for post-stabilization care services;						
1.8 Policies and procedures for accessing specialty/referral care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						The *Member Handbook* and several pharmacy policies address contract requirements for: •Pharmacy co-pay and to whom it applies; •The PDL •How to obtain prescription and non-prescription medications •Prior authorizations •Emergency supplies •Provisions for transitioning members. The following 4 pharmacy policies have not been reviewed in over 18 months: •PMXX-005 •PMX-010 •PMXX-015 •PMXX-020. Onsite discussion confirmed policies undergo annual review. *Recommendation: Ensure policies are reviewed according to your internal process.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						The *Member Handbook* informs members that they will be notified of a change in benefits or services 30 days prior to the effective date. Policy SC_PNXX_303, Provider Termination and Member Notification, page 2, states "If BlueChoice HealthPlan Medicaid learned about the termination after the fact, the letter is sent as soon as possible but no later than 30 calendar days after learning of the termination." The timeframe according to the Federal Regulation is to make a good faith effort to give written notice within 15 days after receipt or issuance of the termination notice. See *42 CFR § 430.10(f) (5)*. *Quality Improvement Plan: Update policy SC_PNXX_303, Provider Termination and Member Notification by including the correct timeframe for notice on page 2 of the policy.*
1.11 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						Policy SC_CSPC_001, PCP Selection and Assignments, define the process for selecting a PCP. PCPs can be changed by the member at any time. Members are informed in the *Member Handbook* how to change their PCP, contacting their PCP first for care outside of an emergency, and how to make or change an appointment. The electronic version of the *Member Handbook* received with the desk materials did not contain a PCP Selection Form as indicated on page 25. BlueChoice demonstrated that the print edition does contain the form and the form can be

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						obtained on the website. *Recommendation: Ensure the PCP Selection Form is available in all versions of the Member Handbook.*
1.12 Procedures for disenrolling from the MCO;						
1.13 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through SCDHHS;						
1.14 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						Members are instructed to call the CCC, request a Provider Directory, or go to the website directory. All the required elements were found on the website *Provider Directory* search feature "Find a Doctor." Onsite discussion confirmed BlueChoice sends a printed Provider Directory to new members. BlueChoice is continually updating the online Provider Directory and contact information is verified during provider relations office visits and secret shopper type phone calls. The *Member Handbook* includes links to the America Medical Association and American Board of Medical Specialists to obtain more information about providers. These links were not functioning at the time of this review. The BlueChoice website is in the process of being updated and the language has changed for easier understanding. (Find a Doctor replaced Provider

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Directory.) This change was not made in the *Member Handbook*. Upcoming changes to the Federal Regulations regarding required Provider Directory content were discussed onsite. *Recommendation: Update the language used in the Member Handbook page 26, to reflect changes to the language used on the website. Ensure links provided for members are functional.*
1.15 Instructions on how to request interpretation and translation services when needed at no cost to the member;						The *Member Handbook* provides complete information on interpretation and translation services.
1.16 Member's rights and protections, as specified in 42 CFR §438.100;						
1.17 Description of the purpose of the Medicaid card and the MCO's Medicaid Managed Care Member ID card and why both are necessary and how to use them;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.18 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						The CCC can answer most questions for members and toll-free and TTY numbers are provided frequently in the *Member Handbook*. Members have the option to e-mail BlueChoice from the website. Instructions to contact certain departments by fax are provided upon request; however, no fax number to the CCC or Member Services area is provided. This item was noted in the previous EQR and a QIP was submitted in which a fax number was included in the *Member Handbook*. It appears this plan was not implemented. See the *SCDHHS Contract (2014), Section 3.9.1.23 and SCDHHS Contract (2016), Section 3.14.1.10.* The score of "Not Met" was due to this uncorrected issue. *Quality Improvement Plan: Update the Member Handbook to include a fax number for members to contact the CCC or Member Services.*
1.19 How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";						
1.20 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services						The *Member Handbook* and the *Provider Manual* include descriptions of EPSDT services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.21 A description of Advance Directives, how to formulate an advance directive and where a member can received assistance with executing an advance directive;						The *Member Handbook* provides excellent information on Advance Directives, Living Wills, and Health Care Power of Attorney. It also explains what these documents are, how they used, and who can assist in the development. The provider's role is defined in the *Provider Manual*.
1.22 The SCDHHS fraud hotline and fraud email address and toll-free line;						The SCDHHS toll-free fraud hotline number and email address is provided in the *Member Handbook* and *Provider Manual*. The BlueChoice Medicaid website includes the *Member Handbook* where members can locate this information; however; there is no direct link to information regarding fraud and abuse on the website. In addition, the search feature is not helpful in finding this information. One document found on the website titled "What to Know About Fraud and Abuse" is dated October, 2008. It does not include the BlueChoice Hotline number as required by the BlueChoice Compliance Plan. *Quality Improvement Plan: Update the BlueChoice website to include easier access to fraud, waste, and abuse information and add the toll-free BlueChoice hotline phone number for members to report fraud and abuse issues.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.23 Additional information as required by the contract and by federal regulation.						*Federal Regulation § 438.3 (d) (4)*, effective July 2017 states "The MCO, PIHP, PAHP, PCCM or PCCM entity will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability." See also the *SCDHHS MCO Contract (2016), Section 3.4.6 and 19.11.* Several versions of this list occur in varying documents including the *Member Handbook* and the *Provider Manual*. *Recommendation: Ensure consistent information is provided to members, staff, and providers regarding anti- discrimination law.*
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Policy SC_QMXX_104, Member Rights and Responsibilities, includes notification of changes in benefits occurs 30 days before the intended effective date of the change. This information is also provided in the *Member Handbook*.
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					Member materials appear to be written in plain, easily understood language. They are available in Spanish and other languages, large format, and audio versions can be provided upon request. Policies define translation thresholds and reading levels per contract requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the MCO, including the availability of free oral translation services for all languages.	X					Access to coverage information and interpreters can be obtained by calling the CCC or the 24 hour Nurseline via toll-free numbers. The toll-free line is available 24 hours a day, 7 days a week, and provides the capability of providing callers with instructions on what to do in case of an emergency, the option to talk directly to a nurse or other clinician or leave a message. The CCC is available as required from 8:00 a.m. until 6:00 p.m. Monday through Friday. The call metrics for the CCC met or exceeded SCDHHS and internal goals for all 4 quarters of 2016. Regular call audits are conducted to ensure CCC staff delivers quality information to members about the health plan benefits and services.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the MCO program, with reeducation occurring as needed.	X					
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to enrollees and members.	X					BlueChoice provided a copy of their Marketing Plan during the onsite visit which defines their marketing guidelines, meeting community needs, and methods used to communicate with potential members. Page 9 of this plan indicates marketing materials will be produced at a 7th grade educational level or lower. Please refer to the *SCDHHS Contract (2016), Section 3.16.1.2 or the 2014 SCDHHS Contract, Section 3.13.1.1.2 and Managed Care Organizations Policy & Procedure*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Guide. *Recommendation: Update the Marketing Plan to indicate materials will be produced below a 7th grade reading level.*
III C. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					The *Member Handbook*, page 67 informs members to contact Healthy Connection Choices to disenroll. It also indicates that BlueChoice can deny a request to leave the plan (disenroll) for cause or good reason. However, only Healthy Connections Choices can deny requests to disenroll from a health plan. *Recommendation: Update the Member Handbook to remove the reference to BlueChoice denying a request to disenroll.*
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. The MCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits.	X					Members are informed of preventive health guidelines in the *Member Handbook*, the BlueChoice website, phone calls from the CCC, direct mailings, and automated phone notifications.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program.	X					BlueChoice provides extra benefits to pregnant members and new parents including car seats and Healthy Rewards gift cards for pregnant members attending prenatal visits and well-child check-ups. New Baby, New Life program is the pre-natal program and pregnant members are screened for high-risk pregnancies. Members at a high risk for premature birth may be followed by a case manager.
4. The MCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits.	X					The *Member Handbook* informs and encourages parents to obtain preventive care and take their children for well visits according to schedule. BlueChoice may also use reminder cards, birthday cards and other means to encourage participation. Services are tracked through claims and HEDIS measures.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					Community events are listed on the BlueChoice website. Page 2 of the *Member Handbook* states one of the extra benefits are community events. Onsite discussion confirms members can learn about the events from flyers left at provider offices, in the community, or by accessing the calendar on the website. There is no guidance in the *Member Handbook* about how members learn about these events. *Recommendation: Update the Member Handbook to include that members may access the calendar of events on the website or call the CCC to learn about community events.*
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. Such assessment includes, but is not limited to:	X					BlueChoice contracts with DSS Research a certified CAHPS survey vendor to do both the child and adult surveys. Response rates for the Adult and Child CAHPS survey were 28.51% and 23.37% respectively. *Recommendation: Implement strategies to increase response rates such as website or email announcements, bulletin postings, call center script additions that remind members of the survey, placing stamps on survey envelopes, and incentives for members.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Statistically sound methodology, including probability sampling to insure that it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse decisions regarding MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					The Service Quality Improvement Committee (SQIC) and CQIC committees analyzed the reports, presented the results, and decided on interventions/initiatives to address problematic areas of member satisfaction.
3. The MCO implements significant measures to address quality problems identified through the member satisfaction survey.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO reports the results of the member satisfaction survey to providers.	X					The results were reported back to the providers in a stand-alone document called "CAHPS Results Provider Notification" via Healthy Connections newsletter. The results of the child survey were not reported to members.
5. The MCO reports to the Quality Improvement Committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					
III F. Grievances						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy SC_GAXX_015 Grievance Process: Members, includes the process used by BlueChoice to manage member grievances. Grievances are conducted by the parent company, Amerigroup.
1.1 Definition of a grievance and who may file a grievance;	X					Policy SC_GAXX_015 Grievance Process: Members, defines a grievance as an expression of dissatisfaction about any matter other than an action (Page 1). Page 2 gives examples of a grievance and may include, but are not limited to: •Quality of care or services provided •Aspects of interpersonal relationships, such as rudeness of a provider or employee •Failure to respect the member's rights. The *Provider Manual* sends the reader to the website glossary for a definition of a grievance.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The website glossary uses the same definition found in the policy. The *Member Handbook*, page 80, under definitions correctly defines a grievances for members as: •Grievance means you state that you're not happy about any matter other than an action. However, page 60 states a grievance is a request to look into an issue you have with quality of care or service. This statement appears to limit the scope of grievances a member could file. Policy SC_GAXX_015 Grievance Process: Members, states members have the right to communicate dissatisfaction about any matter other than an action. Who may file a grievance is correctly detailed in the following documents: •Policy SC_GAXX_015 Grievance Process: Members •*Member Handbook* •Provider Manual *Recommendation: Update the definition of a grievance found on page 60 of the Member Handbook.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 The procedure for filing and handling a grievance;		X				The following documents correctly define that a grievance can be filed verbally, or in writing on a grievance form or a letter. In addition, BlueChoice provides assistance to members filing a grievance: •Policy SC_GAXX_015 Grievance Process: Members • *Member Handbook* • *Provider Manual* A discrepancy was found regarding acknowledging grievances between pages 4 of policy SC_GAXX_015, Grievance Process: Members, and the *Member Handbook*, page 61. The policy indicated verbal grievances are acknowledged verbally and the *Member Handbook* states verbal or written grievances are acknowledged in a letter within 5 calendar days. The CCC conducts training for staff regarding grievances and appeals. The materials were provided as requested and are well done. The document titled "Grievance and Appeal Rights" is found on the website and mailed with grievance acknowledgement and resolution letters. Several corrections were made following the previous EQR. The updated (6/16) document was provided during the onsite. One minor issue remains. Page 1 states 'You must file a grievance within 30 calendar days from the date you first knew that you had an issue." The *SCDHHS MCO Contract (2014), Section 9.1.1.2.1*, states "A grievance may be filed within 30 calendar days of the occurrence." Also

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reference *Federal Regulation § 438.402 (c) (B) (4) (ii) (2)* that goes into effect July 2017. *Quality Improvement Plan: Correct the discrepancy between the policy and the Member Handbook regarding how grievances are acknowledged. Correct the remaining error in the "Grievance and Appeal Rights" document.*
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					BlueChoice has established a grievance resolution timeframe of 30 days from receipt with a possible 14 day extension. This is consistent with the *SCDHHS Contract*. Policy SC_GAXX_015 Grievance Process: Members, also includes a process for clinically urgent grievances or problems to be resolved within 14 calendar days. The timeframe for grievance resolution is correctly documented in the policy, the *Member Handbook*, the *Provider Manual*. Grievance letter templates submitted contained appropriate information for members. The SQIC had identified issues related to timely resolution of grievance over a year ago and an action plan is in place that includes weekly monitoring of timeliness, additional training across several departments, and decreasing the time for mail delivery. The grievance files reviewed did not reflect timeliness as an ongoing issue.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					One file reviewed and discussed onsite involved hospital care and the member feeling she had been misdiagnosed. Appropriate information was obtained and the grievance resolution letter was sent. The file did not indicate that a medical director had been consulted about this potential clinical quality of care grievance. Policy SC_GAXX_015 states on page 6, "The clinical associate reviews all clinical grievances with a Medical Director who was not involved in any previous level of review or decision-making unless there is evidence there is no quality of care issue or the provider has not responded to requests for information." *Recommendation: Develop a training plan for CCC and Grievance and Appeals staff to ensure they are following policy regarding the types of grievances that should be brought to the attention of a medical director for consultation or review prior to resolution.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Verbal grievances that are resolved by the CCC are documented, tracked, and included in the quarterly grievance log format for submission to SCDHHS. Policy SC_GAXX_015 Grievance Process: Members, indicates grievance logs are maintained for at least 5 years. Logs reviewed demonstrate the CCC documents the details of the grievance and includes evidence of CCC staff educating members about plan processes and needed preventive care.
2. The MCO applies the grievance policy and procedure as formulated.	X					The grievance files reviewed documented thorough investigations to resolve grievances and that BlueChoice sends timely acknowledgement and resolution letters. Letters contained appropriate explanations of the action taken by BlueChoice.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy SC_GAXX_015, Grievance Process: Members, page 7, states Amerigroup prepares the quarterly reports which track and trend member grievances- these are reported to the SQIC where they are reviewed. It also states Amerigroup prepares a report that goes to the Credentialing Department bi-weekly. This covers grievances about access, office conditions, appointment systems and documentation. This information is also communicated to provider relations staff. The majority of grievances reported are related to accessing care and billing issues.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					
III G. Practitioner Changes						
1. The MCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					Policy SC_GAXX_015, Grievance Process: Members, defines the process BlueChoice uses to address member requests to leave the health plan. The requests are made by members to SCDHHS Healthy Connections, which sends it back to the plan to investigate and resolve. The plan reports back to SCDHHS.
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					Requests by members to change their PCP due to dissatisfaction are addressed in Grievances and Appeals. They are tracked as grievances and included in tallies and tracking, It is the responsibility of the CQIC and SQIC committees to review tallies and trends, and make suggestions for improvement.
3. The timeliness guideline for completing a member's request to change their PCP is consistent with contract requirements.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					BlueChoice presented the *2017 Quality Assessment Performance Improvement Program Description* for review. The program description is reviewed, updated as needed, and presented to various quality improvement committees and to the Board of Directors for approval. There were two discrepancies noted in the program description. •Page 10 mentions members and community representatives have opportunities for input into the QI program through efforts of the Community Resource Center. There was no information found in the *Member Handbook* or website of this offered opportunity. This was discussed during the onsite and BlueChoice indicated the Community Resource Centers had been closed. •Page 21, under Policies and Procedures Supporting QAPI Programs, indicates that policies and procedures and other materials are reviewed annually and revised when indicated. However, on page 30, under Policies & Procedures, it states policies; procedures and other materials are updated bi-annually. *Recommendation: Correct the 2017 Quality Assessment Performance Improvement Program*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Description and remove the reference to the Community Resource Centers and correct the frequency that policies, procedures and other materials are reviewed and updated.
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.	X					Addressed in the QI program description.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Annually, BlueChoice develops a work plan that outlines the planned QI activities. Revisions and updates are made as needed and reported to the CQIC for approval.
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					BlueChoice's CQIC and their SQIC are charged with authority and accountability for all PIPs and processes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The composition of the QI Committee reflects the membership required by the contract.	X					The CQIC is chaired by Dr. Lloyd Kapp, and the SQIC is chaired by the senior manager, quality improvement and accreditation. There are 11 network providers represented on the CQIC. All are voting members of that committee. Three external physicians are needed to meet the quorum requirements for the CQIC. Page 12 of the *QI Program Description* states this is no quorum needed for the SQIC. *Recommendation: Establish a quorum for the SQIC.*
3. The QI Committee meets at regular quarterly intervals.	X					Both committees meet quarterly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Committee minutes are well documented.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					All HEDIS measures met the protocol guidelines and were considered "Fully Compliant." The comparison from the previous to the current year revealed a strong increase in Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, especially the BMI Percentile measure. There was also an increase in the Asthma Medication Ratio measures. There were decreases in rates of over 10% for a few measures including Use of Spirometry Testing in the Assessment and Diagnosis of COPD, Bronchodilator rates, and asthma medication compliance for 5-11 year olds.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The complete validation results can be found in *Attachment 3, EQR Validation Worksheet*. *Recommendation: Effort should be made to increase the measures that had a drop of more than 10% from last year to this year.*
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					Two PIPS were submitted, one clinical and one non-clinical. The clinical project was titled, "Childhood Immunizations Combo 3 and Lead Screenings." The non-clinical project was titled, "Access and Availability of Care."
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					The Access and Availability of Care was scored at 82% last year, and 96% this year. The Combo 3 and Lead Screenings PIP was scored at 97% last year and was 95% this year; therefore, both projects scored in the High Confidence category and met the validation protocol. The complete validation results can be found in *Attachment 3, EQR Validation Worksheet*.
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					A *Gaps in Care Report* is provided to network PCPs to help identify members experiencing a gap in care. Policy SC_QMXX_048, Clinical Practice Guidelines-Review, Adoption and Distribution, addresses monitoring provider compliance with Clinical Practice

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Guidelines.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					BlueChoice uses the Quality Assessment and Performance Improvement Program Evaluation to evaluate the progress and results of planned activities toward established goals. The 2016 Quality Assessment Performance Improvement Program Evaluation was provided for review.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					BlueChoice contracts with Amerigroup Partnership Plan, LLC (Amerigroup) to provide administrative services for its Medicaid managed care product, including behavioral health, case management, utilization management, maternal-child services, pharmacy management, clinical quality management, and disease management. Each department maintains its own program description and evaluation. The *Utilization Management (UM) Program Description* for 2017 defines the program's scope, goals, objectives, organizational structure, management responsibilities, staff roles and qualifications, and components of the UM Program. The 2017 *UM Program Description* was approved by the CQIC on 4/17/17.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					The *UM Program Description* includes the program's structure and provides an overview of processes to evaluate authorization requests for medical necessity. Additional information on the medical necessity evaluation process is found in various department policies.
1.2 lines of responsibility and accountability;	X					Lines of responsibility and accountability for Amerigroup and BlueChoice are defined in the *UM Program Description*.
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;		X				Timeliness requirements for UM determinations and notifications are addressed in the *UM Program Description*, Policy SC_UMXX_117, Decision and Notification Timeframes, the *Member Handbook*, and the *Provider Manual*. Documentation of extensions of determination timeframes for urgent, pre-service requests was incorrect in the *UM Program Description* (page 19) and Policy SC_UMXX_117, Decision and Notification Timeframes (page 6). Both indicate that when an extension is implemented, the ultimate timeframe for a determination is within 72 hours from receipt of the request. However, onsite discussion confirmed an extension of an urgent, pre-service request allows an additional 14 calendar days, as stated in the *Provider Manual*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Correct the information regarding extensions of the urgent, pre-service determination timeframe in the UM Program Description and Policy SC_UMXX_117.
1.5 consideration of new technology;	X					
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					Information regarding the lack of financial incentives is documented in Policy SC_UMXX_065, Separation of Financial and Medical Necessity Decision-Making, the *UM Program Description*, UM policies, the *Member Handbook*, and the *Provider Manual*. All Amerigroup associates are required to sign an annual attestation regarding compensation.
1.7 the mechanism to provide for a preferred provider program.	X					BlueChoice's *Preferred Provider Program Description* defines the Gold Card status providers may achieve based on historical approval rates of 94% or higher for specific procedure codes. Gold Card status eliminates the need for medical necessity review for the specified procedures. To expand the program, an annual review is conducted for possible amendment of the procedure codes and types of providers allowed to participate in the program. Once a provider has achieved Gold Card status, BlueChoice conducts an annual review to determine the provider's eligibility to continue his/her participation in the program. One provider group has achieved "Gold Card" status and BlueChoice continues to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						evaluate additional providers for inclusion in the program. The 2017 *UM Program Description*, page 35, mentions the Preferred Provider Program but provides no additional information on the program. *Recommendation: Include a description of the Preferred Provider Program in the UM Program Description or refer the reader to the Preferred Provider Program Description to obtain additional information.*
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					An evaluation of the UM Program is conducted annually and results are submitted to the CQIC and SQIC for review and approval. The evaluation's results and recommendations become the basis for the following year's activities. The *UM Program Description* is updated annually based on the annual evaluation results. Medical necessity criteria are reviewed and approved annually by the Medical Policy and Technology Assessment Committee and the CQIC. External providers are included in the membership of the CQIC.
V B. Medical Necessity Determinations						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					Requirements for coverage of hysterectomy, sterilization, and abortion are defined in Policy SC_UMXX_129, Abortions, Sterilizations, Hysterectomies, the *Provider Manual* and the *Member Handbook*. Policy SC_UMXX_129, Abortions, Sterilizations, Hysterectomies, states the Consent for Sterilization form (SCDHHS form 1723) and a Surgical Justification Review for Hysterectomy form must be submitted for sterilization requests. Onsite discussion confirmed both forms are required for sterilization; however, the *Provider Manual* states only the Consent for Sterilization form is required. *Recommendation: Revise the Provider Manual, pages 18 and 68, to include the Surgical Justification Review for Hysterectomy form as a requirement for sterilization requests.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					The *UM Program Description* confirms all reviewers consider the severity of illness and co-morbidities as well as episode-specific variables when determining medical necessity. The goal is to view members in a holistic manner to ensure they receive necessary services. Policy SC_UMXX_118, Utilization Management Decision and Screening Criteria, states application of criteria should be based on the individual needs of the member in accordance with the member's specific benefit plan and the capability of healthcare delivery systems.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Policy SC_UMXX_050, Non-physician Review Audits - Process, Inter-Rater, and Focused, defines processes for inter-rater reliability (IRR) audits, process audits, and focused audits to evaluate consistency in criteria application and UM decision-making. The IRR benchmark is established as 90%. Results are provided SQIC, CQIC, and QIC. The policy does not clearly define the follow-up of IRR scores below the established benchmark. Onsite discussion indicates scores below the benchmark result in formal retraining and retesting of the applicable staff member. Policy SC_UMXX_120, Nurse Inter-Rater, states annual nurse IRR assessments are conducted and results are reported to the CQIC and SQIC. Page 3 of the policy states the IRR benchmark is 80%, which is inconsistent with the benchmark of 90% documented in Policy

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						SC_UMXX_050. Onsite discussion revealed the benchmark was increased to 90% after this policy's last revision and the benchmark will be corrected upon the policy's next review and revision. As discussed during the onsite visit, there appear to be redundancies between Policies SC_UMXX_050 and SC_UMXX_120. Policy SC_UMXX_078, Physician Inter-rater Reliability Assessment, defines annual processes for ensuring consistency in decision-making by peer clinical reviewers. The policy does not indicate to which committee physician IRR results are reported. Onsite discussion confirmed physician IRR results are reported to the SQIC, CQIC, and QIC. *Recommendation: Update Policy SC_UMXX_050 to define the follow-up of IRR scores below the established benchmark. Correct the IRR benchmark in Policy SC_UMXX_120 upon the policy's next review and revision. Consider combining Policies SC_UMXX_050 and SC_UMXX_120 to eliminate redundancies. Include the committees to which physician IRR results are reported in Policy SC_UMXX_078.*
6. Pharmacy Requirements						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Pharmacy formulary restrictions include prior authorization (PA) requirements, quantity limits, and age/gender limits, etc. Over the counter medications are covered with a valid prescription if they are listed on the formulary. The Pharmacy and Therapeutics Committee consists of two interdependent sub-committees—the Clinical Review Committee and the Value Assessment Committee. Both sub-committees include MDs of various specialties and pharmacists, and work to maintain an outcomes-based formulary.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					Drugs not on the formulary, drugs which exceed established limits, and drugs with a prior authorization indicator on the PDL may be covered with PA. As stated in Policy SC_PMXX_005, Provisional Drug Supply Management, all medications requiring PA may be granted a 5-day provisional supply. If the PA cannot be resolved within those 5 days, a 30-day supply will be allowed. Policy SC_PMXX_025, Medicaid Pharmacy Lock-In Program, defines processes for 5-day provisional supply of medications for members in the Pharmacy Lock-in Program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Policy SC_UMXX_101, 24-hour Access to Emergency Department Services, appropriately defines an emergency situation and addresses coverage for post-stabilization services. The *Provider Manual* does not adequately define post-stabilization services and requirements. *Recommendation: Revise the Provider Manual to include complete information on post-stabilization care requirements. Refer to Federal Regulation § 438.114.*
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					Requirements and qualifications for staff members who issue medical necessity approval and denial determinations are defined in the following: •The *UM Program Description* •Policy SC_UMXX_010, Inpatient Continued Stay Review/Care Coordination/Discharge Planning •Policy SC_UMXX_080, Use of Consultant Physicians and Providers for Opinion •Policy SC_UMXX_013, Non-Authorization of Medical Services
10. Initial utilization decisions are made promptly after all necessary information is received.	X					UM approval files demonstrate timely determinations and attempts to obtain additional medical information when needed for decision-making.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					UM denial files reflect appropriate attempts to obtain additional medical information when needed for decision-making.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Denial files confirm timely notifications of determinations. Onsite discussion confirmed members received written, mailed notification and providers are notified verbally and/or via fax at the time of the determination. The denial rationale in two Notice of Action letters reviewed contained acronyms or abbreviations members may not understand and one denial rationale did not clearly convey the reason for the denial decision. *Recommendation: Ensure Notice of Action letters are written in language easily understandable by members and clearly convey the reason the request is not approved.*
V C. Appeals						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the MCO in a manner consistent with contract requirements, including:	X					Appeals processes and requirements are documented in Policy SC_GAXX_051, Member Appeal Process.
1.1 The definitions of an action and an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;		X				Procedures for filing appeals are documented in Policy SC_GAXX_051, Member Appeal Process, the *Member Handbook*, *Provider Manual*, initial denial letter templates, and the "Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid" document. The *SCDHHS Contract, Amendment Two, Section 9.1.1.2.2*, requires the appeal filing timeframe to be at least 30 calendar days from receipt of the Notice of Action. Onsite discussion confirmed BlueChoice allows appeals to be filed within 90 calendar days from the date of receipt of the Notice of Action. Issues noted with the timeframe to file an appeal include: •Policy SC_GAXX_051, Member Appeal Process, page 4, states the appeal filing timeframe is within thirty (90) calendar days from date of receipt of the Notice of Action. •The Member Appeal Request Form found on BlueChoice's website states the appeal filing timeframe is within 90 calendar days from the date on the Notice of Action letter.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						A link to the Member Appeal Request form in the *Provider Manual* (page 102) returns the Grievance Request form instead of the Member Appeal Request form. *Quality Improvement Plan: Correct the timeframe to file an appeal in Policy SC_GAXX_051, Member Appeal Process, page 4, and on the Member Appeal Request Form. Update the link to the Member Appeal Request form in the Provider Manual (page 102) to return the correct form.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;			X			Standard appeal resolution timeframes are correctly documented in Policy SC_GAXX_051, Member Appeal Process, the *Member Handbook*, *Provider Manual*, the "Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid" document, and the Member Appeal Request form. Onsite discussion confirmed BlueChoice allows a 72-

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						hour timeframe for resolution of expedited appeals, as stated in Policy SC_GAXX_051, Member Appeal Process, and the *Member Handbook*. However, the *Provider Manual* states the resolution timeframe is 3 business days or 72 hours. This is an uncorrected deficiency from the previous EQR. The *SCDHHS Contract, Amendment Two, Section 9.1.4.4.1,* states, "The timeline for the Appeal begins with the receipt of the member's initial notification of appeal (oral or written) to the CONTRACTOR." Additionally, the *SCDHHS Contract, Amendment Two, Sections 9.1.6.1.2 and 9.1.6.1.3* state the resolution timeframe begins on the day the appeal is received by the plan. For further information, refer to *Federal Regulation § 438.408* and *§ 438.410*. Issues are noted as follows: •Policy SC_GAXX_051, Member Appeal Process, does not address date of receipt for appeals received after hours and on weekends. During onsite discussion, staff stated when an appeal is received outside of normal business hours, the date of receipt is considered to be the next business day. •The "Your Grievance and Appeal Rights as a Member of BlueChoice HealthPlan Medicaid" document (revised June 2016) states the expedited appeal resolution timeframe is within 72 hours "between Monday and Friday." *Quality Improvement Plan: Correct the expedited appeal resolution timeframe in the Provider Manual,*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						page 103. Revise Policy SC_GAXX_051, Member Appeal Process, to address the date of receipt for appeals received after hours and on weekends. Ensure the appeal resolution timeframe begins on the date the appeal is actually received.
1.6 Written notice of the appeal resolution as required by the contract;	X					Policy SC_GAXX_051, Member Appeal Process, appropriately defines the elements of an appeal resolution letter. Policy SC_GAXX_051, Member Appeal Process, Section K (page 7) addresses the requirement to send standard appeal resolution letters via certified mail. Section M (page 8) of the policy does not clearly address the requirement to send expedited appeal resolution letters via certified mail. Onsite discussion and follow-up documentation confirm that all appeal resolution letters are sent via certified mail. *Recommendation: Revise Section M of Policy SC_GAXX_051, Member Appeal Process, to clearly indicate expedited appeal resolution letters are sent via certified mail.*
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.	X					Review of appeal files revealed the following: •One expedited appeal was processed under the standard appeal resolution timeframe without medical director review to determine the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appropriateness of the expedited request. •One appeal resolution letter was sent outside of the required timeframe for notification of resolution. The letter was sent on day 41 after receipt. Onsite discussion confirmed this was an error. *Recommendation: Ensure appeals are processed within the appropriate timeframe for the type of request and that appeal resolution notification letters are sent within the required timeframes.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Per Policy SC_GAXX_051, Member Appeal Process, quarterly reports which track and trend State Fair Hearing requests are presented to the SQIC. The SQIC reviews the requests, including those regarding access to care and quality of care, to identify and address trends. In addition, the Grievance and Appeal department performs monthly internal audits of appeal files for compliance with regulatory and accrediting requirements. Audit performance data is analyzed and outliers/problems are identified for corrective action. Review of SQIC confirms reporting and discussion of appeal data.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Case Management						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO utilizes case management techniques to insure comprehensive, coordinated care for members with complex health needs or high-risk health conditions, including populations specified in the contract.	X					Policy GBD CM-019, Case Management Program Case Identification, Policy SC_CAXX_007, Care Management Targeting/Case Finding, and the *Case Management (CM) Program Description* address methods to identify members who may benefit from CM services. Policy SC_CAXX_108, Targeted Case Management - Identification and Referral of Eligible Members, defines processes for targeted case management (CM) services including assessment to determine level of needs, development of an individualized care plan, referral to appropriate external resources, monitoring, evaluation, and follow-up. Policy SC_CAXX_106, Case Management Documentation, defines documentation requirements for CM files, including monitoring and follow-up, ongoing assessment, revisions to the care plan, and communication with the member/member's representative. CM files reflect appropriate CM processes are followed in the admission of members to CM, assessment, care plan development, monitoring, revision, and follow-up.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under and over utilization of medical	X					Policy SC_UMXX_061, Under- and Over-Utilization of Services-Monitoring, defines processes for monitoring

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
services as required by the contract.						utilization trends (at least four elements) annually.
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					Documentation in the *2016 SC Under and Over Utilization Report* confirms BlueChoice analyzes data on the following topics regarding utilization: •ER visits per 1000 member months •Inpatient setting discharges per 1000 member months (acute care medicine) •Selected procedures (back surgery and bariatric weight loss surgery)

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					BlueChoice has delegation agreements with the following: •Greenville Health Systems (GHS)—credentialing and complex case management •University Medical Associates (UMA)—credentialing •Vision Service Plan (VSP)—credentialing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Roper St. Francis—credentialing Policy HP 003-12, Oversight of Delegated Activities, and Policy MCD-10, Credentialing Delegation, outline processes for pre-delegation assessment of potential delegates as well as for oversight of delegated activities. The table of contents in the 2017 *Case Management Program Description* indicates information addressing delegation of case management functions can be found on page 23 of the program description. However, examination of the program description reveals no information regarding delegation of case management functions on page 23 or elsewhere in the document. The Delegation Agreement Template for credentialing, page 2, includes, "Query of the Excluded Parties List Service administered by the General Services Administration" as a credentialing and recredentialing requirement. However, the GSA discontinued the EPLS website and now directs users to the SAM portal (www.sam.gov). Credentialing requirements for NPs found in the *SCDHHS MCO P&P Guide, Section 6.1.1.10*, are not addressed in the Delegation Agreement Template. Onsite discussion revealed BlueChoice has educated delegates regarding the requirements specific to NPs and has encouraged the delegates to include the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						requirements in their credentialing plans. Onsite discussion confirmed that annual oversight includes verification that all requirements for NP credentialing are conducted by the delegate. *Recommendation: Revise the Case Management Program Description to include information on delegation of case management functions or remove the reference to the information from the table of contents. Upon the next revision of the Delegation Agreement Template, remove the reference to the EPLS as a credentialing and recredentialing requirement.*
2. The MCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	X					Evidence of annual oversight conducted within the last year was provided for all delegated entities. Of note, the ongoing issue noted in previous external quality reviews regarding failure of VSP to collect ownership disclosure forms has been resolved satisfactorily. Credentialing Committee, SQIC, and QIC minutes reflect annual oversight activities are reported appropriately.

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					Policy SC_PCXX_009, Pediatric Preventive Services/Provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, defines methods used to educate providers on EPSDT services, including immunizations, and reporting required immunization data to the State Immunization Information System (SIIS). A *Gaps in Care Report* is generated at least quarterly and disseminated to providers. Provider compliance with administering required immunizations is evaluated via random medical record reviews conducted by nurse reviewers.
1.2 performing EPSDTs/Well Care.	X					Per Policy SC_PCXX_006, Preventive Health Guidelines (PHGs) - Review, Adoption, Distribution and Performance Monitoring, PCPs are encouraged to contact new and established members to encourage participation in regular preventive health care. PCPs must document all services rendered in the member's medical record. The provision of EPSDT services is monitored through medical record reviews. Practitioners scoring less than the minimum of 90% on an individual criteria category receive an intervention related to the category.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Results of the medical record reviews are reported to the CQIC.
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			The following deficiencies were noted during the previous EQR and remain uncorrected: •In the previous EQR, BlueChoice indicated they would add the appointment standard "Health Maintenance/Preventive Care: within 8 weeks" to the *Provider Manual*. However, the information does not appear in the *Provider Manual* received in the desk materials. •No fax number to the Customer Care Center or Member Services area is provided in the *Member Handbook*. •BlueChoice follows a 72 hour timeframe for resolution of expedited appeals, but the *Provider Manual* states the resolution timeframe is "3 business days or 72 hours." *Quality Improvement Plan: Ensure all deficiencies identified in the EQR are addressed and the corrections are implemented.*